

CMGD PATIENT REGISTRATION FORM

PATIENT'S DATE OF BIRTH	MALE or FEMALE	SOCIAL SECURITY	MR. , MRS., DR. , or OTHER
PATIENT'S LAST NAME	FIRST NAME	MIDDLE INITIAL	JR. , SR., or OTHER
HOME STREET ADDRESS		CITY	STATE
			ZIP
HOME TELEPHONE #	WORK TELEPHONE #	MOBIL #	E-MAIL ADDRESS
EMPLOYER'S NAME	MARRIED, SINGLE, or OTHER	SPOUSE'S NAME/S.O.	
EMERGENCY CONTACT NAME AND TELEPHONE #		PREFERRED PHARMACY & TELEPHONE #	
PREFERRED LANGUAGE	DO YOU HAVE A HEALTHCARE WILL, i.e., ADVANCE DIRECTIVE or DURABLE POWER OF ATTORNEY? Y or N		
INSURED'S LAST NAME (If Different from Patient)	FIRST NAME	MIDDLE INITIAL	
INSURED'S SOCIAL SECURITY	DATE OF BIRTH	RELATIONSHIP TO PATIENT	HEALTHPLAN
<p>AUTHORIZATION FOR TREATMENT: The undersigned consents, whether he/she signs as agent or as patient, to treatment as necessary or desirable but not restricted to whatever drug, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending physician, or qualified designate.</p>			
Patient Signature/Parent/Guardian:		Date:	
DO NOT WRITE BELOW THIS SECTION			
HEALTHPLAN	TELEPHONE #	REP. NAME	VERIFIED BY
PCP	IPA		EFF. DATE
CO-PAY/DEDUCTIBLE\$		MEMBER #	
COMMENTS			