Patient Registration

marable
PERSONAL HEALTHCARE

PATIENT INFORMATION

Date: _____

Patient Name: _____ DOB: _____
Gender: O Male O Female
Home Address: _____
Email Address: _____
Phone #: Cell _____ Home _____ Work _____

EMERGENCY CONTACT INFORMATION

Name: _____
Relationship: _____
Phone #: Cell _____ Home _____ Work _____

INSURANCE INFORMATION

Insurance Carrier Name: _____
Plan Name: _____
Group ID: _____ Member ID: _____

* * * IMPORTANT * * *

PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.
MARABLE PERSONAL HEALTHCARE DOES NOT BILL INSURANCE.
THIS INFORMATION IS USED TO ASSIST WITH SPECIALIST REFERRALS, LAB ORDERS, AND PRIOR AUTHORIZATION FOR PRESCRIPTIONS AND IMAGING STUDIES.