

# DIVINE HANDS HOME HEALTH LLC.

## CLIENT REGISTRATION FORM

Today's date:			PCP:			
<b>PATIENT INFORMATION</b>						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.: ***_**_****		Home phone no.:	
P.O. box:		City: Baltimore		State: MD		ZIP Code:
Occupation:		Employer:			Employer phone no.: ( )	
Chose clinic because/Referred to clinic by (please check one box):						<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital
<input type="checkbox"/> Dr. _____						
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other

<b>INSURANCE INFORMATION</b>						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:		Birth date:	Address (if different):		Home phone no.: ( )	
Occupation:		Employer:	Employer address:		Employer phone no.: ( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance						
<input type="checkbox"/> [Insurance]		<input type="checkbox"/> [Insurance]		<input type="checkbox"/> [Insurance]		
<input type="checkbox"/> [Insurance]		<input type="checkbox"/> [Insurance]		<input type="checkbox"/> [Insurance]		
<input type="checkbox"/> [Insurance]		<input type="checkbox"/> [Insurance]		<input type="checkbox"/> Welfare (Please provide coupon)		
<input type="checkbox"/> Other						
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						

<b>IN CASE OF EMERGENCY</b>				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize DIVINE HANDS HOME HEALTH LLC. or insurance company to release any information required to process my claims.				
_____ Patient/Guardian signature			_____ Date	

