MILL CREEK SELECT
PATIENT REGISTRATION FORM

Social Security #_____ Today's Date:_____
Name:_____ Date of Birth:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone:(___)_____ Work Phone:(___)_____
Cell Phone:(___)_____ Other Phone:(___)_____
Email address:_____

Circle One
Sex: Male Female
Marital Status: Single Married Divorced Widowed

Patient's Employer:_____
Employer's Address:_____
(Street) (City, State, Zip)
How did you hear about us? (circle one):

Friend Newspaper Yellow Pages Doctor/Dentist Other:_____

BILLING AND INSURANCE INFORMATION

Name of Insurance Company:_____
ID#_____ Group #_____
Name of Policy Holder_____ DOB:(policy holder)_____
SSN (policy holder)_____
Secondary Insurance:_____
ID#_____ Group#_____
Name of Policy Holder_____

FAMILY MEMBERS

Female Head of Household_____ DOB:_____

Male Head of Household_____ DOB:_____

Child/Dependent_____ DOB:_____

Child/Dependent_____ DOB:_____

Child/Dependent_____ DOB:_____

Other Family Members:_____