MID COAST MEDICAL CLINIC
Registration Form

Patient #______________(Office Use) **PLEASE PRINT**

Patient's Name	Home Telephone Number	E-Mail Address

Patient's Street Address	City, State, Zip

Patient's Mailing Address	City, State, Zip

Date of Birth	Race	Age	Sex	Social Security Number	Driver's License Number	Martial Status

Patient's Employer	Occupation	Work Telephone Number

Employer's Street Address	City, State, Zip

Spouse's Name	Date of Birth	Social Security Number	Driver's License Number	Work Telephone Number

Spouse's Employer	Employer's Address

INSURANCE INFORMATION – Please present your insurance card to the front desk

	Insurance Company	Policyholder	Certificate Number	Group Number
1				
2				

Nearest Local Relative Not Living With You	Address	Telephone Number

IF PATIENT IS A MINOR OR A STUDENT

Father's Name	Street, City, State, Zip	Home Telephone Number

Father's Employer	Work Telephone	Social Security Number	Driver's License Number	Date of Birth

Mother's Name	Street, City, State, Zip	Home Telephone Number

Mother's Employer	Work Telephone	Social Security Number	Driver's License Number	Date of Birth

I hereby authorize Mid Coast Medical Clinic Physicians, Physician Assistants and/or staff to discuss my protected health information with:

Name	Relationship	Telephone Number

____ ________________________
Signature of Patient or Legally Authorized Representative **Date**

____ ________________________
Signature of Witness **Date**