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REGISTRATION FORM

(Please Print)

Today's date:				PCP:			
PATIENT INFORMATION							
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?	If not, what is your legal name?		(Former name):		Birth date:	Age:	Sex:
<input type="checkbox"/> Yes <input type="checkbox"/> No					/ /		<input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone:		
					()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone:		
					()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Internet	<input type="checkbox"/> Other			
Other family members seen here:							
Email Address:				Can we contact you via email? <input type="checkbox"/> Yes <input type="checkbox"/> No			

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date:	Address (if different):			Home phone no.:	
		/ /				()	
Is this person a patient here?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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		

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone:
			()
			()
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 [Name of Practice] or insurance company to release any information required to process my claims.			
Patient/Guardian signature			Date