



3839 Merle Hay Road Suite 229  
Des Moines, IA 50310

## REGISTRATION FORM

(Please Print)

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:	Apt#:	City:	State:    ZIP Code:
Occupation:	Employer:		Employer phone no.: (    )
Referred by:		DHS Worker:	
Mother:	Address:	Phone:	Alt. Phone:
Father:	Address:	Phone:	Alt. Phone:
Current Placement Name:	Address:	Phone:	Alt. Phone:
Relationship (circle one) Relative / Foster / Residential			

Phone: (515) 327-5195

Fax: (515) 334-5566

### 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						
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"/> [Title 19]	<input type="checkbox"/> Blue Cross/Blue Shield	<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. [state ID#]:	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 no.: ( )	Work phone no.: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Life Connections, L.C. I understand that I am financially responsible for any balance. I also authorize Life Connections, L.C. to release any information required to process my claims.			
_____ <i>Patient/Guardian signature</i>		_____ <i>Date</i>	

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