

# Patient Registration Information

Please PRINT AND complete ALL sections below!

<b>PATIENT'S PERSONAL INFORMATION</b>			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Name:					Date of Birth: / /		SSN: - -	
Last Name ↑			First Name ↑		Middle ↑			
Address:			Apt #:		City:		State: Zip:	
Home Phone: ( )			Cell Phone: ( )			Work Phone: ( )		
E-Mail Address					Employed: Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> or Student FT <input type="checkbox"/>			
Employer			Employer Phone ( )		Address			
Spouse's Name:			SSN:		DOB:		Employer:	
Is Visit related to an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No or Workers Comp Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of injury _____ **Provide Auto Ins / Work Comp Info								
<b>RESPONSIBLE PARTY IF PATIENT IS A MINOR (COMPLETE PAGE 2)</b>								
NAME:					RELATIONSHIP:			
<b>PATIENT'S INSURANCE INFORMATION</b>			<b>Please present insurance cards or other information to receptionist.</b>					
PRIMARY Ins:			Insured's name:			Date of Birth: / /		
Patients Relationship to Insured:		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			Policy / ID #:			
Claims Address:					Group #:			
SECONDARY Ins:			Insured's name:			Date of Birth: / /		
Patients Relationship to Insured:		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			Policy / ID #:			
Claims Address:					Group #:			
<b>Emergency Contact (Someone not living in the same home) :</b>								
Name:						Relationship:		
Home Phone: ( )			Work Phone: ( )			Cell Phone: ( )		

**\*Do you have a Living Will? Y N \*Do you have an Advanced Directive? Y N - \*If Yes - Please Provide Copies**

**AUTHORIZATION • ASSIGNMENT OF BENEFITS • FINANCIAL AGREEMENT** I hereby authorize the release of any medical information for the treatment, payment and healthcare operations. I assign the benefits payable for physician services to Family Medical Center. I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account. I understand that if for any reason my account should be sent to a collection agency, I may be responsible for that collection agency fee. I further agree that a photocopy of this agreement shall be as valid as the original.

√ \_\_\_\_\_  
**Patient or Guardian Signature** **Date**

Also, the event that I cannot be reached by phone, I authorize BPC/FMC to leave a message with a family member, or on my answering machine. I understand and accept this consent.

√ \_\_\_\_\_  
**Patient or Guardian Signature** **Date**

**RECEIPT OF NOTICE**  
 I, \_\_\_\_\_, have received a copy of BPC's Notice of Privacy Practices.

√ \_\_\_\_\_  
**Patient or Guardian Signature** **Date**

**(For Office Use Only)**  
 Consent received by \_\_\_\_\_ Date \_\_\_\_\_ Added to Medical Record by \_\_\_\_\_ Date \_\_\_\_\_  
 Consent refused by patient and witnessed by \_\_\_\_\_

**IF PATIENT IS A MINOR CHILD**

**PROVIDE THE FOLLOWING INFORMATION:**

**Father's Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Social Security#** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Mother's Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Social Security#** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_