

Patient Registration Information

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION		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: Last Name ↑ First Name ↑ Middle ↑					Date of Birth: / /	SSN: - -	
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							
RESPONSIBLE PARTY IF PATIENT IS A MINOR (COMPLETE PAGE 2) NAME: RELATIONSHIP:							

PATIENT'S INSURANCE INFORMATION		Please present insurance cards or other information to receptionist.					
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 #:			
Emergency Contact (Someone not living in the same home) : Name: Relationship:							
Address:		Apt #:	City:		State:	Zip:	
Home Phone: ()		Work Phone: ()		Cell Phone: ()			

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: _____

