FAMILY MEDICAL GROUP, P.A.
PATIENT REGISTRATION

PATIENT INFORMATION

Name: ______________________________ Date of Birth:____________ Age:________
Last First Middle Maiden

Social Security #:______________________ Sex: M F Marital Status: S M D Sep W Race: ______________

Mailing Address: *Street:*______________________ *City:*______________ *State:*__________ *Zip:*__________

Secondary Address: *Street:* ______________________ *City:*______________ *State:*__________ *Zip:*__________

Phone Numbers: Home ______________ Cell ______________ E-Mail ______________________

Occupation: ________________ Employer Name & Address:______________________________

Spouse Name:__________________ Occupation: __________________ Phone #:______________

Parents Names (if minor child):______________________ Address: ______________________

Parents Phone Numbers (if minor child): Home ______________ Cell ______________ Work ______________

Emergency Contact:________________ Relationship: ______________ Phone #:______________

How did you hear about our practice? ____

RESPONSIBLE PARTY

Name: ______________________ Date of Birth: ______________Social Security #:______________

Address: ______________________________ Home & Cell Phone #:______________________

Employer Name & Address:______________________________________ Phone #:______________

If patient is over the age of 18: I ______________________ (*name and relationship to patient*) agree to take financial

responsibility for ____________________ until otherwise notified. Driver's license #:__________________

INSURANCE INFORMATION

Primary Insurance Name: ______________________ Policy Number:____________ Group Number:____________

Subscriber Name:______________________________ Relationship to Patient: ______________________

Date of Birth: ____________SS#:__________________

Secondary Insurance Name: ______________________ Policy Number:____________ Group Number:____________

Subscriber Name:______________________________ Relationship to Patient: ______________________

Date of Birth: ____________SS#:__________________

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I certify the information provided on this form is correct. My signature represents my written consent for examination and treatment by personnel of Family Medical Group, PA. I understand that I am financially responsible for any charges I might incur regardless of any contracts I may have with insurance companies, attorneys or Medicare. I hereby assign all medical/surgical benefits to Family Medical Group, PA and understand that I am financially responsible for all charges whether or not paid by my insurance company. I also understand that co-pays, deductibles and any past due balance will be collected at time of service. I hereby authorize Family Medical Group, PA to release all medical and general information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: ____ Date: ______________________

Patient signature or Parent/Guardian if under 18 years old