WELCOME TO FAMILY MEDICINE P.C.

PATIENT REGISTRATION NEW PATIENT ☐ UPDATE ☐ TODAYS DATE: _____

NAME:

FIRST: _____ MIDDLE: _____ LAST: _____

ADDRESS/STREET: _____

CITY: _____ STATE: _____ ZIP: _____

PARENTS NAMES IF A MINOR: _____

HOME PHONE: _____

CELL PHONE: _____

BUSINESS PHONE: _____

EMAIL ADDRESS: _____

DOB: MONTH _____ DAY _____ YEAR _____

SS#: ___ - ___ - ___ GENDER: MALE: ☐ FEMALE: ☐

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED

RESPONSIBLE PARTY: SELF OTHER _____

EMPLOYER: _____

ADDRESS: _____

PHONE: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

DAYTIME PHONE#: _____ BUSINESS PHONE#: _____

CELL PHONE#: _____

ADDITIONAL INFORMATION

WE WANT TO MAKE SURE THAT ALL OUR PATIENTS GET THE BEST CARE POSSIBLE. WE WOULD LIKE YOU TO TELL US YOUR RACIAL/ETHNIC BACKGROUND AND PREFERRED LANGUAGE SO THAT WE CAN REVIEW THE TREATMENT THAT ALL PATIENTS RECEIVE AND MAKE SURE THAT EVERYONE GETS THE HIGHEST QUALITY OF CARE.

PRIMARY LANGUAGE: _____

RACE: (CIRCLE ONE): BLACK/ AFRICAN AMERICAN, WHITE/ CAUCASIAN,ASIAN, AMERICAN INDIAN/ ALASKA NATIVE, NATIVE HAWAIIAN/ PACIFIC ISLANDER. I Prefer Not To Answer.

FAITH: _____

ETHNICITY: (CIRCLE ONE): AFRICAN AMERICAN, ARAB, JAMAICAN, CHINESE, JAPANESE, KOREAN, GERMAN,IRISH, HISPANIC, LATINO, ITALIAN, LEBANESE, MIDDLE EASTERN, SCANDINAVIAN, SLAVIC. I Prefer Not To Answer.

INSURANCE INFORMATION

PRIMARY: _____

INSURANCE ID: _____

POLICY GRP/FECA: _____

POLICY HOLDERS NAME: _____

POLICY HOLDERS DOB: _____

SECONDARY: _____

INSURANCE ID: _____

POLICY GRP/ FECA: _____

POLICY HOLDERS NAME: _____

POLICY HOLDERS DOB: _____

PHARMACY NAME: _____

ADDRESS: _____

PHONE#: _____

ASSIGNMENT AND RELEASE

I HEREBY AUTHORIZED PAYMENT DIRECTLY TO FAMILY MEDICINE P.C. OF ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR THE SERVICES RENDERED. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE, AND FOR ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.
I AUTHORIZED THE ABOVE DOCTOR AND OR ANY PROVIDER OR SUPPLIER OF THE SERVICES IN THIS OFFICE TO RELEASE THIS INFORMATION REQUIRED SECURING THE PAYMENT OF THE BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

SIGNATURE OF RESPONSIBLE PARTY _____

DATE: _____