PATIENT REGISTRATION
FAMILY MEDICINE ASSOCIATES MILLARD

NAME_____ _____ _____ **Sex**: M F **Please circle one**: Married Single Divorced Separated Widowed Minor Child
first middle I last

ADDRESS_____ **BIRTHDATE**_____
Street Name or PO Box

_____ **SS#**_____-_____-_____
City State Zip Code

PHONE #1_____ **home** EMPLOYER_____

PHONE #2_____ **cell** ADDRESS_____

PHONE #3_____ **work** OCCUPATION_____

EMAIL ADDRESS:

NAME OF SPOUSE (if married) **NAME OF PARENT #1 (if minor)** **NAME OF PARENT #2 (if minor)**

_____ _____ _____

EMPLOYER_____ EMPLOYER_____ EMPLOYER_____

PHONE #_____ PHONE #_____ PHONE #_____

PLEASE LIST ALL PERSONS LIVING AT HOME AND RELATIONSHIP:_____

_____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS:_____

REFERRED BY:_____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?

NAME:_____

PHONE #'s: **RELATIONSHIP:**

NAME OF PERSON WHO CARRIES PRIMARY INSURANCE _____ **BIRTH DATE**_____

EMPLOYER_____ **RELATIONSHIP TO PATIENT**_____

NAME OF PERSON WHO CARRIES 2ND INS. IF ANY _____ **BIRTH DATE**_____

EMPLOYER: **RELATIONSHIP TO PATIENT:**

PRIVACY/PERMISSION TO RELEASE HEALTH INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS:

DO WE HAVE PERMISSION TO:

LEAVE A MESSAGE ON YOUR ANSWERING MACHINE @ HOME WITH RESULTS? YES NO

LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT? YES NO

IS THERE ANYONE WITH WHOM WE MAY DISCUSS YOUR HEALTH INFORMATION? YES NO

IF YES, WHOM & RELATIONSHIP:_____

AUTHORIZATION TO RELEASE INFORMATION AND INSURANCE ASSIGNMENT

I authorize payment direct to the above named physician(s) of any insurance benefits affording coverage to the named patient but not to exceed the physician's regular fees for such services. I understand that I am financially responsible for all charges. I also authorize the release of such information as may be necessary to the proper authorities.

CODING COURTESY

As a courtesy, we will submit your claim for all services to your insurance company. Please remember your individual health insurance policy is a contract between you and your insurance company, and we are not a party to that contract. Be aware that some of our services may not covered by your insurance policy. By presenting for care, you agree that you are responsible for all services and charges, regardless of your insurance status. Should any provided services not be covered by your insurance, we will not alter your claim, change your diagnosis, or report a different service than what was performed in order that your insurance will cover the charge. You will be responsible for the balance.

_____ _____

SIGNATURE OF PATIENT OR PARENT IF MINOR **DATE SIGNED**