ADULT REGISTRATION/UPDATE

PLEASE FILL OUT THIS FORM COMPLETELY. THANK YOU.

PATIENT INFORMATION:

Name:_____ Birthdate:_____ Sex M F

Address:_____ Social Security #:_____

City/State/Zip:_____/_____/_____

Home #:_____Cell #:_____Email:_____

Race: (Please Circle One) 1. Caucasian 2. African American 3. Asian 4. American Indian/Alaska Native

4. Native Hawaiian or Other 5. Pacific Islander 6. More than one race

Ethnicity: (Please Circle One) 1.Non-Hispanic or Latino 2.Hispanic or Latino

Who referred you to our office? (Please circle one) Patient Insurance Online Other _____

List Allergies to Medications:_____

EMERGENCY CONTACT INFORMATION: (Please provide two contacts)

Who to notify in case of emergency: Name:_____

Phone #:_____

Who to notify if above doesn't answer: Name:_____

Phone:_____

INSURANCE SUBSCRIBER INFORMATION: (Policy Holder's Information)

Please Circle one: Self Father Mother Husband Wife Subscriber Date of Birth:_____

Retired? (Please circle and skip below) Yes No

Employer Name:_____ (Fill in if the Insurance is through Employment)

Work Phone #:_____

Address:_____

City/State/Zip:_____/_____/_____

Social Security #:_____

******INSURANCE- PLEASE BRING ALL INSURANCE CARDS TO THE RECEPTIONIST EVERY VISIT******

***** OVER*****

*****ALL PATIENTS***

I hereby authorize release of information necessary to file a claim payable with my insurance company and assign benefits otherwise payable to me, to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier.

_____ _____/_____/_____

Signature **Date**

*****MEDICARE PATIENT *ONLY***

I request that payment of authorized Medicare benefits be made either to me or on my behalf to The Family Doctor for any services furnished to me by the physician, physician assistant, or nurse practitioner. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services. I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act.

_____ _____/_____/_____

Signature **Date**