FAMILY PRACTICE ASSOCIATES

Patient Registration

Patient Name: Address: City, State, Zip: Telephone: Home:		Date:	
Address: City, State, Zip: Telephone:	PATIENT INFORMATION		
Address: City, State, Zip: Telephone:	Patient Name:		
City, State, Zip: Telephone: Home:			
Telephone: Home:			
Date of Birth:	Telephone: Home:	Work:	Sex: M F
Social Security Number: Employer:	Date of Birth:	Marital Status: M	_ S W
Nearest Relative:			
Address: Telephone:		Relationship:	
Type of Insurance:			
Policy Number: Subscriber of Insurance: Subscriber's Social Security Number: Subscriber's Date of Birth: Address: Employer: Subscriber's Relationship to Patient: Does Our Office Have Your Medical Records?: OTHER INSURANCE Type of Insurance: Subscriber: Policy Number: ALL PROFESSIONAL SERVICES RENDERED THROUGH THIS OFFICE ARE CHARGED TO THE PATIENT. NECESSARY INSURANCE FORMS WILL BE COMPLETED PER INFORMATION RECEIVED FROM PATIENT, AND SENT TO THEIR RESPECTIVE CARRIER. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. INSURANCE AUTHORIZATION AND ASSIGNMENT: Name of Patient:	RESPONSIBLE PARTY		
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Subscriber's Relationship to Patient:	Subscriber's Social Security Number:	per: Subscriber's Date of Birth:	
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	INSURANCE AUTHORIZATION AND AS	SIGNMENT:	
request that payment of authorized Medicare/Other Insurance company benefits be made to Family	Name of Patient:		
Practice Associates on my behalf for all services furnished me by my physician. 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 or the benefits payable to related services.	Practice Associates on my behalf for all se medical information about me to release to	ervices furnished me by my physicia o the Health Care Financing Admin	an. I authorize any holder of istration and its agents any
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I realize I am fully responsible for the payment of any deductible, coinsurance and noncovered services.			
Signature: Date:	Signature:	Date:	

Please present <u>ALL</u> insurance cards to receptionist.