FAMILY PRACTICE ASSOCIATES
Patient Registration

Date: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Telephone: Home: _____ Work: _____ Sex: M ☐ F ☐
Date of Birth: _____ Marital Status: M ☐ S ☐ W ☐
Social Security Number: _____ Employer: _____
Nearest Relative: _____ Relationship: _____
Address: _____ Telephone: _____

RESPONSIBLE PARTY

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: _____

I request that payment of authorized Medicare/Other Insurance company benefits be made to Family 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.

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: _____

Please present ALL insurance cards to receptionist.