PATIENT REGISTRATION
F A M I L Y M E D I C A L C E N T E R

PATIENT:

NAME_____ **BIRTHDATE**_____ **SEX** ___**M** ___**F**
(Last) (First) (MI)

ADDRESS_____ **CITY**_____ **ST**____ **ZIP**_____

MARITAL STATUS (SMWD)_____ **TELEPHONE #(**_____**)**_____**SS#**_____

RESPONSIBLE PARTY:

NAME_____ **BIRTHDATE**_____ **SEX** ___**M** ___**F**

ADDRESS_____ **CITY**_____ **ST**____ **ZIP**_____

MARITAL STATUS (SMWD)_____ **TELEPHONE #(**_____**)**_____ **SS#**_____

RELATIONSHIP TO PATIENT_____ **E-MAIL ADDRESS**_____

EMPLOYER_____ **FT PT** (Circle One) **WORK PHONE #(**_____**)**_____

EMPLOYER ADDRESS_____

SPOUSES NAME_____ **BIRTHDATE**_____ **SS#**_____

SPOUSES EMPLOYER_____ **FT PT** (Circle One) **WORK PHONE #(**_____**)**_____

OTHER:

NAME, ADDRESS & TELEPHONE # OF NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU

_____

INSURANCE COMPANY & INSURANCE COMPANY ADDRESS	**POLICY # ID#**	**SUBSCRIBER NAME & BIRTHDATE**
#1_____	_____	_____
_____	_____	_____
#2_____	_____	_____
_____	_____	_____

I authorize release of medical or hospital information by the Family Medical Center, P.A. to my insurance company(s) on behalf of myself and any dependents for whom I am authorized to grant such authority for processing insurance claims. I further authorize payment of benefits from Medicare and/or my insurance company(s) to the Family Medical Center, P.A. for services rendered by myself and/or my dependents. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as the original.

SIGNATURE_____ **DATE**_____

INTERNAL USE ONLY: