Patient Registration
Family Medicine Center, Inc.

Patient Information

Last Name___________________________________First Name_______________________MI__________
Date of Birth___________________________Social Security #_______-_______-____________
Address____
City____State_________Zip________________
Home Phone______-______-____________Work Phone______-______-_______________
Known Allergies______________________Marital Status: S M D W Gender: Male____ Female_____
Employer____
Employer's Address____
EMERGENCY CONTACT (Name and phone)____

Responsible Party for insurance and bills: (Circle) Patient, Spouse, Parents, Mother, Father, Other_______
(If patient is under 18, or in guardianship, list legal guardian or custodial parent)

Last Name___________________________________First Name______________________MI____________
Date of Birth______________________Social Security# _______-______-______________
Address (if different)____
City____State________Zip__________________
Home Phone _______-_______-_______________ Work Phone _______-______-________
Employer____
Employer's Address____

Primary Insurance Company____
Name of Policy Holder______________________Policy #__________________Group #___________________
Relationship to card holder: Self ______ Spouse ______ Dependent _______

Secondary Insurance Company____
Name of Policy Holder______________________Policy #__________________Group #___________________

Financial Responsibility
I consent to assign all payments for these services to the Family Medicine Center, Inc. I understand that I am responsible for all co-payments, amounts applied to deductible and other amounts that may be deemed my responsibility by the Family Medicine Center, Inc. as required by my contract with my insurance plan and state regulations. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Co-pays are to be paid at the time of service, we do not "bill for co-pays". Reasonable efforts must be made to pay balances at the time of service. Past due balances will incur finance charges.

Self Pay patients are patients with no insurance, carry insurance not accepted at this office, or patients without a valid insurance card on file at our office. Payment for medical care is expected at the time of service.

Patient/Guardian____Date____________________
12/2002