FAMILY PRACTICE ASSOCIATES
PATIENT REGISTRATION

PATIENT NAME_____**SS#**_____-_____-_____
Last **First** **MI**

Address: _____
Street City State Zip

Home Ph # _____Cell #_____Work #_____

E-mail Address: _____

Spouse's Name: _____Parent's names if pt is a minor_____

Person responsible for bill: _____
Address and phone (if different from patient) _____

Emergency Contact (other than home, work #)
Name: _____Relationship_____Phone_____

INSURANCE INFORMATION
Primary Insurance_____Is this insurance through an employer? Yes No

If yes, name and phone of employer:_____

Policy holder: _____DOB:____/____/____ SS#_____-_____-_____

Relationship to Patient: Spouse_____ Parent_____Other_____

Secondary Insurance _____Is this insurance through an employer? Yes No

If yes, name and phone of employer_____

Policy Holder: _____DOB:____/_____/____SS#_____-_____-_____

Relationship to Patient: Spouse_____Parent_____Other_____

PLEASE READ AND SIGN BELOW

Insurance Release:
I hereby authorize the physician to release to nay party responsible for payment any information acquired in the course of medical information or treatment including but not limited to information regarding psychiatric, HIV treatment and/or testing. A Photostat of this authorization shall be considered as valid as the original.

Authorization to Pay Benefits to Physician:
I hereby authorize Family Practice Associates to process and receive direct payment for all Medicare assigned and/or mayor medical benefits from insurance companies, noted above for any medical services provided. I recognized my financial obligation to pay any co-insurance, deductible and non-covered services provided as required. The policy of this office is that the parent who presents and requests treatment for a child is responsible for all fees associated with the services rendered.

Signature of Patient, Parent or Legal Guardian_____**Date**_____

We treat personal and health information securely and confidentially. We limit access to personal information to only those persons who need to know that information to provide services to patients. As required by the Health Information Portability and Accountability Act of 1996, you have the right to request the opportunity to inspect and copy health information that pertains to you. Please see our privacy policy posted in the waiting room.
Signature_____**Date**_____