PATIENT REGISTRATION FORM

Last Name_____First Name_____Middle Initial_____

Address_____ Sex (circle) M F Marital Status_____

City_____ State_____ Zip_____ Date of Birth_____

Home phone_____ Cell phone_____ Work phone _____

Employer_____

Emergency Contact_____Relationship_____Phone_____

If patient is under 18 – Mother's name_____ daytime phone_____
Father's name_____ daytime phone_____

SEND BILLS TO (person responsible for paying balance after insurance pays)
Last Name_____First Name _____ Middle Initial_____

Address_____ Sex (circle) M F Marital Status_____

City_____ State_____Zip_____Date of Birth_____

Home phone_____ Cell phone_____ Work phone _____

INSURANCE INFORMATION:

Primary Insurance_____	Secondary Insurance_____
Policyholders' Last Name_____	Policyholder's Last Name_____
Policyholder's First Name_____	Policyholder's First Name_____
Relationship to patient_____	Relationship to Patient_____
DOB_____ Sex M F SSN_____	DOB_____ Sex M F SSN_____
ID# _____Group#_____	ID# _____Group#_____

IT IS IMPORTANT THAT YOU KNOW THE EXTENT OF YOUR INSURANCE COVERAGE. IF YOUR INSURANCE REQUIRES YOU TO SEE A PARTICIPATING PROVIDER, IT IS YOUR RESPONSIBILITY TO MAKE SURE THAT OUR PHYSICIAN IS PARTICIPATING.

I authorize Franconia Family Medicine, P.C. to release any and all information obtained in the course of my treatment to my insurance company as well as to other medical providers participating in my health care. I authorize payment of medical benefits directly to Franconia Family Medicine, P.C. and accept full financial responsibility for all non-covered services. If my account is turned over to a collection agency, I will pay the agency fee. Franconia Family Medicine, P.C. does not guarantee outcome of treatment.

Signature_____Date_____