Patient Registration Form

DEMOGRAPHICS

Patient Name (as it appears on insurance card)________________________________ DOB:____________

Nickname:_________________ Gender:_______ SSN:________________Marital Status:____________

Parent/Legal Guardian (if patient is a minor):____

Relationship to patient:____

Street Address: ____Apt:__________

City:____ State:__________ Zip code:_____________

Email:______________________________________ Employer:______________________________

Check preferred phone number:

◯ Home:______________________ ◯ Cell:______________________ ◯ Work:_____________________

◯ I give Family First Primary Care permission to contact me at the phone numbers listed above. I understand that contact includes automated calls, such as appointment reminders and balance notifications, as well as, calls from staff regarding my healthcare.

Preferred Language:_____________________ Race:_________________ Ethnicity:________________

Preferred Pharmacy:___________________________________ Pharmacy Phone:__________________

Pharmacy Address: ____

◯ I give Family First Primary Care permission to obtain my prescription history through the Medication History Authority so that we may maintain an accurate record of all medications prescribed to you, both within Family First Primary Care, as well as other medical facilities. This will aid our practitioners in prescribing the most beneficial medications based on your history.

◯ How did you hear of Family First Primary Care?____

EMERGENCY CONTACT

Name:____ Phone:________________________

Relationship to Patient: ____

People with whom my healthcare information can be shared: (please list name and relationship to Patient)

1.____ 2.______________________________________

3.____ 4.______________________________________

By signing below, I authorize my healthcare information to be shared with the above listed individuals.

Signature: ____Date:__________________

What healthcare information can we share with those listed above?

◯ Financial / Billing
◯ Laboratory / Blood Test Results
◯ Radiology Results
◯ Medications, changes and directions for use
◯ Other medical information
◯ Diagnosis / Treatment Plans

INSURANCE INFORMATION

Primary Insurance: ____
Subscriber ID:____ Group: _________________
Policy Holder: ____ DOB: __________________
Relationship to Policy Holder: _______________________________ Co-Pay: ________________

Secondary Insurance: ____
Subscriber ID: ____Group_________________
Policy Holder: ____ DOB: _________________
Relationship to Policy Holder: _______________________________ Co-pay: _______________

By signing below, I agree that the information is correct to the best of my knowledge:

Signature: ____Date:__________________