Information about the PATIENT:

Patient Name: ______________________ Date of Birth: ______________

Address: ______________________

City/State/Zip: ______________________ Home Phone: ______________

E-mail ______________________

Social Security #: ______________________ Cell Phone: ______________

Employer: ______________________ Work Phone: ______________

Preferred Pharmacy: ______________________ Phone: ______________

If the patient is a minor, complete the information below:

Parent or Guardian: ______________________ Relationship: ______________

Home Phone: ______________________ Work Phone: ______________

Address: ______________________ Cell Phone: ______________

Information about your PRIMARY insurance:

Insurance Name: ______________________

Policyholder Name: ______________________ Date of Birth: ______________

Social Security #: ______________________ Relationship: ______________

ID Number: ______________________ Group #: ______________

If you have secondary insurance, complete the information below:

Insurance Name: ______________________

Policyholder Name: ______________________ Date of Birth: ______________

Social Security #: ______________________ Relationship: ______________

ID Number: ______________________ Group #: ______________

Release of Information, Authorization for Assignment of Benefits and Financial Agreement

I authorization Family First Physicians to release to my insurance company or its representatives information including diagnosis and the records of any treatment or examination rendered to me that they may be required to process my claim for benefits.

I authorize and request that my insurance company (commercial or governmental) pay directly to Family First Physicians the amount due me in pending claims for medical treatments or services by reason of such treatments or services rendered to me. This assignment will remain in effect until revoked by me in writing.

It is understood that, whether I sign as patient or responsible party, I am directly responsible for services rendered which are not paid by my insurance. I certify that to the best of my knowledge, the information contained on this Patient Registration Form is correct and true. I will notify Family First Physicians in case of any changes in the information contained on this form.

Patient Signature: ______________________ Date: ______________

Parent/Guardian Signature: ______________________ Date: ______________