FAMILY FIRST PHYSICIANS

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: _____