Patient Registration Form

Is today's visit work related?

If yes, do not complete this form. Please see the front desk staff for instructions.

Employees Only

Employee Initials:
Insurance Ver:
CC on File:

Was this the result of a motor vehicle accident? Yes No

How did you hear about us? ____________________

What's the reason for your visit today? ____________________

PATIENT INFORMATION

Name: Male Female

Date of Birth: SS#:

Mailing Address: Apt#:

City: State: Zip:

Home Ph#:

Cell Ph#:

Home Email:

Employer Name:

Address:

City:

State:

Zip:

Phone:

Email:

For more information on the confidential phone and email, please see the attached consent form.

EMERGENCY CONTACT INFORMATION

Name:

Relationship:

Home Ph#:

Cell Ph#:

Based on government regulations, we are required to ask the following:

What is your preferred language:

Race: I prefer not to answer

Ethnicity: I prefer not to answer

Best Form of Contact: Cell Home Email Mail

Best Time to Call: May we leave a message? Yes No

INSURANCE INFORMATION

Primary Ins: Ins #:

Name of Insured:

Date of Birth:

Relationship to Patient: Self Spouse Parent Other

Secondary Ins: Ins #:

Name of Insured:

Date of Birth:

Relationship to Patient: Self Spouse Parent Other

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

Check if same as patient information. If not, please complete the entire section.

Name: ☐ Male Female

Date of Birth: SS#:

Relationship:

Phone #:

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office are due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all costs of collection fees and/or attorney's fees and all court costs if any. I agree to be contacted at any telephone number or email address associated with my account. This includes cellular telephone numbers or other wireless devices. I understand this could result in a charge from my phone or device carrier to me for talk time, SMS messaging/texts or data usage for emails or voice mails. I also understand methods of contact may include pre-recorded /artificial voice messages and/or the use of automatic dialing devices as applicable.

Signature

Date

CONSENT FOR TREATMENT

I, the undersigned, consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

Signature Date

NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

Signature Date

This AFC location is owned and operated by: