american family care®
The Right Care. Right Now.

1444 West Passyunk Ave
Philadelphia, PA. 19145

Phone: 215.964.9250 | Fax: 215.964.9445

Monday - Friday: 8:00 AM - 8:00 PM
Saturday & Sunday: 8:00 AM - 5:00 PM

Patient Registration Form

Please fill out form completely. See Notice of Privacy Practices.

STOP ***Is today's visit work related? If yes: Do not complete this form. Please see front desk staff for instructions.***

Patient's Full Name: _____ Social Security #: _____

Date of Birth: _____ Sex: ❑ M ❑ F **REASON FOR VISIT:** _____

Street Address /Apt #: _____

_____

City, State, Zip: _____ ***Was this the result of a motor vehicle accident?*** ❑ Yes ❑ No

Home Phone: _____ Leave message: ❑ Yes ❑ No How did you hear about us? _____

Local or Cell Phone: _____ Leave message: ❑ Yes ❑ No Home Email Address: _____

Work Phone: _____ Confidential Email Address: _____

Best form of contact? ❑ Home ❑ Cell ❑ Other Emergency Contact: _____

Primary Care Physician: _____ Emergency Contact Phone: _____

Primary Care Phone or City & State: _____ Relationship to Patient: _____

Based on government regulations we are required to ask the following information: ❑ *I prefer not to answer*

Preferred Language: _____ Race: ❑ American Indian or Alaska Native ❑ Asian

Ethnicity: ❑ Hispanic or Latino ❑ Black or African American ❑ Caucasian

❑ Non Hispanic or Latino ❑ Native Hawaiian or Other Pacific Islander

GUARANTOR INFORMATION

❑ *Check if same as patient information and sign at X below. If not, please complete entire section and sign.*

Name: _____ Sex: ❑ M ❑ F Relationship to Patient: ❑ Spouse ❑ Parent ❑ Other

Date of Birth: _____ SSN#: _____ Guarantor Employer: _____

Street Address /Apt #: _____ Employer Phone: _____ Ext #: _____

City, State, Zip: _____

Home Phone: _____

Local or Cell Phone: _____ Email: _____

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is 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 that my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees, and/or attorney's fees and all court costs, if any.

X: _____ **DATE:** _____

Patient/Guarantor Signature

INSURANCE INFORMATION

Primary Insurance Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name: _____ Subscriber Name: _____

Policy ID: _____ Group Number: _____ Subscriber Date of Birth: _____

Secondary Insurance *(if applicable)* Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name: _____ Subscriber Name: _____

Policy ID: _____ Group Number: _____ Subscriber Date of Birth: _____

CONSENT FOR TREATMENT

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

SIGNED: _____ **DATE:** _____

Patient/Guardian Signature (if patient is a minor)

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

SIGNED: _____ **DATE:** _____

Patient/Guardian Signature (if patient is a minor)