



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: _____

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.

Home Phone: _____

X: _____ **DATE:** _____
Patient/Guarantor Signature

Local or Cell Phone: _____ Email: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Plan Name: _____

Relationship to Insured: Self Spouse Child Other

Policy ID: _____ Group Number: _____

Subscriber Name: _____

Secondary Insurance (if applicable)

Insurance Plan Name: _____

Relationship to Insured: Self Spouse Child Other

Policy ID: _____ Group Number: _____

Subscriber Name: _____

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)