PATIENT REGISTRATION

NAME: _____ DATE OF BIRTH _____
LAST FIRST MI

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE(HOME): _____ WORK: _____ CELL: _____

SOCIAL SECURITY NUMBER: _____ SEX: MALE OR FEMALE

PATIENT EMPLOYER: _____

NAME OF PRIMARY INSURANCE CO: _____

HOLDER OF INSURANCE (NAME): _____

RELATIONSHIP TO PATIENT: _____ POLICY HOLDER'S DOB: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

NAME OF SECONDARY INSURANCE CO: _____

HOLDER OF INSURANCE (NAME): _____

RELATIONSHIP TO PATIENT: _____ POLICY HOLDER'S DOB: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

IF MINOR:
MOM'S SS#: _____ DAD'S SS#: _____

I consent to treatment for the care I am receiving at Chapel View Family Care. I authorize the release of all medical records to the referring and family physicians and to my insurance company if applicable. I acknowledge full financial responsibility for medical services rendered by Chapel View Family Care and understand that payment for any services not covered by insurance will be my responsibility. I understand that any copayments are due at the time of service. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of charges. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

SIGNATURE: _____ DATE: _____

EMAIL: _____

HOW DID YOU HEAR ABOUT US?

- ☐ Family/Friend
- ☐ Sign on Building
- ☐ Insurance Company
- ☐ Internet
- ☐ Other _____