

PATIENT REGISTRATION FORM

Welcome to Family Medical Associates of Raleigh!

Please complete this entire form, or notify our staff if you are unable to.

PATIENT INFORMATION

Last Name: _____ First: _____ M.I. _____

D.O.B. ____/____/____ SS# _____ Sex: M or F Race: _____

Mailing Address: _____ Apt.# _____

City: _____ State: _____ Zip: _____

Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____

If your Physical Address is different than your mailing address, please state: _____

Apt. # _____ City: _____ State: _____ Zip: _____

Employer/School _____

Spouse's Name: _____ Spouse's Employer: _____

Emergency Contact Person: _____ Phone # _____

Do you have health insurance? _____ Yes _____ No

RESPONSIBLE PARTY IF NOT SELF (PARENT OR GUARDIAN)

Last Name: _____ First: _____ M.I. _____

D.O.B. ____/____/____ SS# _____ DL # _____ DL State: _____

Sex: M or F Race _____

Mailing Address: _____ Apt.# _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION (PLEASE PRESENT YOUR INSURANCE CARD WITH THIS FORM)

Primary Ins. _____ Name of Policy Holder _____ D.O.B. ____/____/____

Relationship: _____ Policy # _____ Group# _____

SS# _____ Employer: _____

Secondary Ins. _____ Policy Holder _____ D.O.B. ____/____/____

Relationship: _____ Policy # _____ Group# _____

SS# _____ Employer: _____

CONSENT FOR TREATMENT: The undersigned hereby consents to treatment and examinations of the patient by providers of Family Medical Associates of Raleigh and to the performance of any surgical or diagnostic procedure which is deemed necessary.

HIPAA: I have received a copy of the Notice of Privacy Practices for Family and hereby authorize the release of medical information necessary for the purposes of determining eligibility for payment of insurance benefits or to a physician's office which I have been referred to as a result of my care at this facility. I authorize Family Medical Associates of Raleigh to leave messages regarding my medical treatment at the numbers listed above **except for:** _____. I also authorize Family Medical Associates of Raleigh to share my medical treatment information with the following individuals: _____.

FINANCIAL RESPONSIBILITY: The responsibility for payment of this bill is yours regardless of insurance coverage. We do not accept responsibility for collecting a claim or for negotiating a settlement on a disputed claim. **Payment in full is expected at the time of service.**

Patient Signature: _____

Date: _____