

Capital Family Physicians, PA

Patient Registration Form

Chart #: _____

Name: _____
Last First M.I. Maiden

Address: _____
Street Apt.#

City State Zip Code

SS#: _____ Birthdate: ____/____/____ Sex: ____ Marital Status (please circle one) S M D W O

Home Phone #: _____ Cell Phone #: _____

Patient Employer: _____ Work #: _____ ext: _____

(IF PATIENT IS A MINOR)

Father's Employer: _____ Mother's Employer: _____

Work #: _____ ext. _____ Work #: _____ ext. _____

INSURANCE INFORMATION

Primary Insurance

Name of Insurance Co: _____

Policy Holder: _____

Relationship to Patient: _____

Birthdate: _____

SS#: _____

ID#: _____

Group #: _____

Employer Name and Address: _____

Secondary Insurance

Name of Insurance Co: _____

Policy Holder: _____

Relationship to Patient: _____

Birthdate: _____

SS#: _____

ID#: _____

Group #: _____

Employer Name and Address: _____

Financial Agreement and Authorization for Treatment

I authorize treatment of the person named above. I agree to pay all charges for myself and all dependents, shown by statements, promptly upon receipt; unless credit arrangements are agreed upon in writing. It is also agreed that all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection. I also acknowledge that I have read the Capital Family Physicians financial and office policy, and will adhere to it.

Signature: _____ Date: _____

Authorization to Release Information

I hereby authorize the physician to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers or others involved in processing and collections of your claims.

Signature: _____ Date: _____

Acknowledgement of Privacy Practices

I hereby acknowledge that I have received a copy of Capital Family Physicians notice of privacy practices. This notice describes how information about me may be used or disclosed, in accordance with Health Insurance Portability and Accountability Act, (HIPAA).

Signature: _____ Date: _____

Emergency Contact Information

I authorize Capital Family Physicians to contact the person listed below in case of emergency.

Name: _____ Relationship: _____

Work Phone #: _____ Home Phone #: _____

Patient's Signature: _____ Date: _____