

**Medical Park Family Care
Patient Registration**

PATIENT INFORMATION

Name _____	Patient ID# _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address _____	Date of Birth _____	
_____	Social Security # _____	
City, State, Zip _____	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other	
Home Phone _____	Email _____	
Work Phone _____	Referral Source _____	
Mobile Phone _____	Preferred Pharmacy _____	

PATIENT EMPLOYMENT INFORMATION

Employed Retired Unemployed Other

Employer Name _____

Employer Phone# _____

Occupation _____

EMERGENCY CONTACTS

Name _____	Relationship _____	Phone _____
_____	_____	_____
_____	_____	_____

RESPONSIBLE PARTY (If patient is under 18 years of age)

Name _____ <input type="checkbox"/> M <input type="checkbox"/> F	Employer _____
Address _____	Home/Mobile Phone _____
_____	Work Phone _____
City, State, Zip _____	SSN _____
	Date of Birth _____

PRIMARY INSURANCE

Insurance Carrier Name _____

Relationship to Insured _____

Insurance ID# _____

Group/Policy # _____

Subscriber Name _____ M F

Subscriber Phone # _____

Subscriber Employer _____

Subscriber SS# _____

Subscriber Date of Birth _____

SECONDARY INSURANCE

Insurance Carrier Name _____

Relationship to Insured _____

Insurance ID# _____

Group/Policy # _____

Subscriber Name _____ M F

Subscriber Phone # _____

Subscriber Employer _____

Subscriber SS# _____

Subscriber Date of Birth _____

Is there anyone else we can speak with regarding this account?

Billing Medical Scheduling

_____	_____	_____
Name	Relationship	Date of Birth
_____	_____	_____
Name	Relationship	Date of Birth

INSURANCE AUTHORIZATION AND ASSIGNMENT

I attest that the information that I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to Medical Park Family Care, and authorize the clinic to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid by my insurance carrier.***

PATIENT/GUARDIAN SIGNATURE

DATE