Medical Park Family Care
Patient Registration

PATIENT INFORMATION

Name _____ Patient ID# _____ Sex ☐ M ☐ F
Mailing Address _____ Date of Birth _____
_____ Social Security # _____
City, State, Zip _____ Marital Status ☐Married ☐Single ☐Divorced ☐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 _____ ☐M ☐F
Address _____
_____
City, State, Zip

Employer _____
Home/Mobile Phone _____
Work Phone _____
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 carrer. ***I understand that I am responsible for any amount not paid by my insurance carrier.***

_____ _____
PATIENT/GUARDIAN SIGNATURE **DATE**