

PATIENT REGISTRATION

AC# _____

Last Name: _____ First Name: _____ Middle Name: _____

D.O. B. ____ / ____ / ____ Gender: _____ Social Security Number ____ - ____ - ____

Marital Status: Single () Married () Divorced () Widowed () Other () _____

Parent / Guardian (if patient is under 18 years old) _____

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell/Mobile Phone _____

Email Address _____

Employer _____

Preferred Pharmacy Name & Address _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone #: _____

Emergency Contact Street Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

INSURANCE AND BILLING INFORMATION

Name of Insured (if other than patient) _____

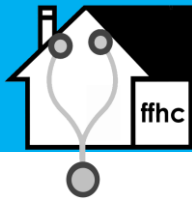
Relationship to Patient _____ D.O.B: ____ / ____ / ____

Insurance Company _____ Phone _____

Insurance Company Address _____

Insurance ID# _____ Policy/Group# _____

Medicare# _____ Medicaid# _____



TREATMENT AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE DR. BIROTTE-SANCHEZ AND OR OTHER DOCTORS, NURSES AND HEALTH CARE PROFESSIONALS WORKING FOR FAITH FAMILY HEALTH CARE, TO TREAT ME OR MY MINOR CHILD.

I UNDERSTAND IT IS MY RESPONSIBILITY TO PAY FOR SUCH SERVICES EVEN IF I HAVE INSURANCE COVERAGE BENEFITS. I HEREBY ASSIGN SUCH INSURANCE BENEFITS TO FAITH HEALTH CARE AND/OR ITS HEALTH CARE PROFESSIONAL AND AUTHORIZE DIRECT PAYMENT TO THEM FOR SERVICES RENDERED TO ME OR MY MINOR CHILD.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE BENEFITS.

I HEREBY AUTHORIZE FAITH FAMILY HEALTH CARE TO RELEASE ANY NECESSARY MEDICAL OR PERSONAL INFORMATION THAT MAY BE NEEDED TO FACILITATE PAYMENT FOR SERVICES.

NAME (please print): _____

SIGNATURE: _____ DATE: ____/____/____