FAMILY MEDICAL CARE, LTD
PATIENT REGISTRATION

DATE: _____

LAST NAME: _____ FIRST: _____ M.I. _____

D.O.B.: _____AGE: _____SEX: _____ MARITAL STATUS: _____

S.S. # _____ HOME PHONE # (_____) _____

CEL PHONE # ( ) _____ EMAIL _____

ADDRESS: _____ CITY: _____ST._____ ZIP: ____

Emergency Contact: _____ Emergency Phone #. _____
(Nearest Relative Not Living With You)
Relationship: _____

Name of Spouse, Patient or Guardian: _____

Their Mailing Address: _____

City, State, Zip: _____ Telephone # _____

WORK INFORMATION

EMPLOYER: _____ ADDRESS: _____

CITY: _____ ST: _____ZIP: _____WORK PHONE# _____

IN CASE OF EMERGENCY CONTACT
OR RESPONSIBLE FOR CHILDREN UNDER 18

LAST NAME: _____ FIRST: _____ M.I.:_____

ADDRESS: _____ CITY: _____ST_____ ZIP: ____

PHONE NUMBER: _____ RELATIONSHIP TO PATIENT: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ PHONE # _____

INSURANCE ADDRESS: _____ CITY:_____ST:_____ZIP:_____

POLICY HOLDERS NAME _____ _____Birth Date: _____

GUARANTOR ADDRESS: _____S.S. # _____

RELATIONSHIP: _____GROUP #:_____POLICY#:_____

Guarantor Employer: _____Guarantor Phone #_____

I CONSENT FOR TREATMENT

I HEREBY AUTHORIZE THE PHYSICIANS AT FAMILY MEDICAL CARE, LTD, MEDICAL STAFF, UNDER THEIR DIRECTION, TO CONDUCT SUCH EXAMINATIONS, ADMINISTER TREATMENT AND MEDICATIONS AS THEY DEEM NECESSARY OR ADVISABLE. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO FAMILY MEDICALCARE, LTD SHOULD THE EXCEPTIONAL CIRCUMSTANCE ARISE WHERE INSURANCE IS ACCEPTED. I HEREBY AUTHORIZE THE RELEASE OF INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MY FAMILY OR INSURANCE COMPANY.

DATE: _____SIGNATURE:_____

ACKNOWLEDGEMENT OF RECEIPT OR KNOWLEDGE OF FAMILY MEDICAL CARE LTD PRIVACY NOTICE

I, _____, acknowledge that I have either been given or have been made Aware of FAMILY MEDICAL CARE, LTD, "Notice of Privacy Practice". I have had full opportunity to read And consider the contents of this Notice Of Privacy Practices.

Signature: _____ Date: _____

If you signed this receipt as a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Date Of Birth of Patient: _____

I give authorization to the following people to receive my protected health / medical information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____