PATIENT REGISTRATION FORM

PATIENT INFORMATION **DATE COMPLETED**_____
Name _____
Address _____ City, State, Zip _____
Home Phone (___)_____ Cell Phone (___)_____ Birthdate _____
SS# _____ Marital Status _____ Sex of Patient ( ) Male ( ) Female

PATIENT EMPLOYMENT INFORMATION (Parent/Guardian employment if patient is a minor)
Employer _____
Address _____ City, State, Zip _____
Work Phone (___)_____ Occupation _____

RESPONSIBLE PARTY INFORMATION (Parent/Guardian if patient is a child)
Name _____
Address _____ City, State, Zip _____
Home Phone (___)_____ Cell Phone (___)_____ Relationship _____

PRIMARY INSURANCE CARRIER EFFECTIVE DATE OF COVERAGE _____
Insurance Co. _____ Member Name _____
Date of Birth _____
Address _____ City, State, Zip _____
Member # _____ Group # _____

SECONDARY INSURANCE CARRIER EFFECTIVE DATE OF COVERAGE _____
Insurance Co. _____ Member Name _____
Date of Birth _____
Address _____ City, State, Zip _____
Member # _____ Group # _____

EMERGENCY NOTIFICATION/NEXT OF KIN (Not living at same address – Daytime Contact)
Name _____
Address _____ City, State, Zip _____
Home Phone (___)_____ Cell Phone (___)_____

ALL RELATIVES LIVING IN THE HOME: SPOUSE AND/OR DEPENDENT(S)
NAME – FIRST & LAST HOW RELATED TO YOU BIRTHDATE

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS/CONSENT FOR TREATMENT

I authorize the release of any medical information necessary to process my insurance claim(s) or as needed by my insurance carrier. I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original. I am responsible for payment for all services rendered to me. I also consent for treatment for myself (any minor children in my care) by OFP. I have reviewed the above information and to the best of my knowledge it is correct as written. I hereby agree to the Release of Authorization/Assignment of Benefits.

Signed (patient or representative) DATE

PATIENT REGISTRATION FORM (cont'd)

Due to increased requirements imposed on medical practices by the Federal Government, we are asking that you supply additional information for our records. Questions regarding race, ethnicity and preferred language must be answered by all patients, effective August 27, 2012. Thank you for your understanding.

PATIENT NAME _____

DATE OF BIRTH _____ **SOCIAL SECURITY NUMBER** _____

RACE (Please Circle) White African American American Indian Eskimo/Aleut

Asian/Pacific Islander Other Unknown Patient Refused

Ethnicity (Please Circle) Hispanic or Latino Not Hispanic or Latino Declined

Preferred Language (Please Circle) English Spanish

Patient E-mail address _____ Do not have E-mail ___

_____

Signed (patient or representative) Date

Revised 08/22/2012