PATIENT REGISTRATION FORM
ADVANCED FAMILY MEDICINE, PLLC

PATIENT INFORMATION *(please write information about the patient here.)*

PATIENTS NAME (Last, First Middle Initial) SEX ☐ Male ☐ Female	AGE SOCIAL SECURITY NUMBER DRIVERS LICENCE
PATIENTS ADDRESS	CITY STATE ZIP
TELEPHONE ( )	MERITAL STATUS ☐ Single ☐ Separated ☐ Widowed ☐ Married ☐ Divorced DATE OF BIRTH _____/_____/_____ MO DAY YR

INSURANCE INF0RMATION *(Please write information about the patient's insurance here.)*

PRIMARY INSURANCE COMPANY NAME	SECONDARY INSURANCE COMPANY NAME
INSURED'S ID NUMBER GROUP PLAN NUMBER	INSURED'S ID NUMBER GROUP PLAN NUMBER

POLICYHOLDER INFORMATION **(Complete the information below if the PATIENT is NOT the POLICYHOLDER)**

PRIMARY POLICYHOLDERS NAME (Last, First, Middle Initial) DATE OF BIRTH _____/_____/_____ MO DAY YR	SECONDARY POLICYHOLDERS NAME (Last, First, Middle Initial) DATE OF BIRTH _____/_____/_____ MO DAY YR
SOCIAL SECURITY NUMBER RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ PARENT _____ OTHER	SOCIAL SECURITY NUMBER RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ PARENT _____ OTHER
EMPLOYER'S NAME PHONE NUMBEF ( ) ( )	EMPLOYER'S NAME PHONE NUMBEF ( ) ( )

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY'S NAME (Last, First,Middle Initial) SEX ☐ MALE ☐ FEMALE	SOCIAL SECURITY NO. DRIVER LICENSE NO. LEGAL REPRESENTATIVE ☐ YES ☐ NO
RESPONSIBLE PARTY'S ADDRESS STATE ZIF	EMPLOYER'S NAME TELEPHONE ( )
TELEPHONE RELATIONSHIP TO PATIENT ( ) ☐ SPOUSE ☐ PARENT ☐ GUARDIAN _____ OTHER	EMPLOYER'S ADDRESS STATE ZIF

IN CASE OF AN EMERGENCY WHO SHOULD WE CONTACT?

(Please list someone living at a residence other than those listed on the reverse side)

NAME	PHONE DAY ( ) ( ) PHONE EVENING ( ) ( )
ADDRESS	CITY STATE ZIP

Please remamber that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responcibility to pay any deductible ammount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

I authorise the release of any information necessary to determine liability for payment and to obtain reimbursement of the claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including medicare, private insurance and other health plans to the practice named on the other side of this form.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid and original. I understand that I am financially responcible for all charges whether or not paid by said insurance.

I agree to the assignments and financial responsibilities shown on the top of this form. You should read those terms carefully.

SIGNATURE X _____ DATE_____

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose you record to others unless you direct us to do so or unless the law authorizes to compels us to do so. You may see your record or get more information about it by contacting our manager (Privacy Officer)

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information.

By my signature bolow I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature _____ **Date** _____

Printed name if signed on behalf of the patient _____ **Relationship (parent, legal guardian, personal representative)** _____