MIDGARDEN FAMILY CLINIC

UPDATED REGISTRATION FORM

(Please Print)

Today's date:	Ethnicity: Hispanic, Non Hispanic

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Race: American Indian, Asian, Black/African American ,

Nat Hawaiian, White, Other ______________

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I hereby authorize the providers of Midgarden Family Clinic PC and their designates to provide medical treatment and release of information pertaining to my treatment for insurance purposes. I understand I am financially responsible for all professional services rendered. I authorize my insurance company to pay benefits directly to the physician. I understand I am responsible to supply all necessary information, such as insurance information and current copy of my card, so that insurance can be properly filed. I further agree to pay all collection costs, reasonable attorney fees, and other collection costs that may be incurred to enforce collection of any amounts outstanding.

______________________________ ______________

Patient/Guardian signature *Date*