



Patient Registration Form

Primary Physician: Dr. Ayo Dr. Davis

Please PRINT AND COMPLETE all information below .

Patient's Information

Please present driver's license and insurance card(s) to receptionist.

Last Name: _____ First Name: _____ Middle Initial: _____ Sex: _____
Mr/Mrs/Ms/Dr: _____ Sr/Jr etc: _____ Nickname: _____ Maiden: _____ Birthdate: ____ / ____ / ____
Social Security No.: _____ - ____ - ____ Marital Status: Single Married Divorced Separated (circle one)
Address: _____ Apt: _____ City: _____ State: _____ Zip: _____
Home Phone: () _____ Cell: () _____ E-mail: _____
Employer/Title OR if Student, Name of School/Grade: _____ / _____
Address: _____ Work Phone: () _____

Patient's Insurance Information

Primary Insurance: _____ Effective Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Policy Holder Name: _____ Birthdate: ____ / ____ / ____ Relation to Patient: _____
Policy Number: _____ Group Number: _____ Copay: \$ _____
Secondary Insurance: _____ Effective Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Name Policy Holder: _____ Birthdate: ____ / ____ / ____ Relation to Patient: _____
Policy Number: _____ Group Number: _____ Copay: \$ _____

Patient's/Responsible Party Information

Last Name: _____ First Name: _____ Middle Initial: _____ Sex: _____
Address: _____ Apt: _____ City: _____ State: _____ Zip: _____
Home Phone: () _____ Cell: () _____ E-mail: _____
Social Security No.: _____ - ____ - ____ Birthdate: ____ / ____ / ____ Work Phone: () _____

Pharmacy

Please list primary pharmacy information.

Name: _____ Is this a mail order pharmacy? Yes No (circle one)
Address: _____ City: _____ State: _____ Zip: _____
Phone: () _____ Fax: () _____

Turn OVER to complete remaining form!

In Emergency, Please Contact

Last Name: _____ First Name: _____ Middle Initial: _____ Relation: _____
Address: _____ Apt: _____ City: _____ State: _____ Zip: _____
Home Phone: () _____ Cell: () _____ Work Phone: () _____

Referral

How did you hear about our practice? (Please circle one) Brochure Mailing Family Member Friend
Insurance Company Newspaper Previous Patient Physician Referral Yellow Pages

List name of newspaper/physician/friend so we may thank them: _____

Assignment of Benefits/Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to FAMILY HEALTH CENTER, PLLC, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I further understand copays are due and payable at the time of service and will be paid accordingly. I hereby authorize FAMILY HEALTH CENTER, PLLC, and its physicians/employees to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

DATE: _____ Patient/Guardian (if under 18) Signature: _____