Patient Registration Form

Primary Physician: Dr. Ayo

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**: _____

Policy Holder Name: _____ **Birthdate**: ___/___/___ **Relation to Patient**: _____

Policy Number: _____ **Group Number**: _____ **Copay**: $_____

Secondary Insurance: _____ **Effective Date**: _____

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:** _____