**REGISTRATION FORM**

(Please Print)

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| **PATIENT INFORMATION** |
| Patient’s Last Name: First: Middle: |  Mr. Miss Mrs. Ms. |
| Marital Status (Circle One):Single / Mar / Div / Sep / Wid | Email: | Birth Date: / / | Age: | Sex: M F Other |
| Race (Circle One):Caucasian/ African American/Asian/Other | Ethnicity (Circle One):Hispanic or Latino/ Not Hispanic or Latino/ Other/ Do Not Wish to  Disclose  | Preferred Language: |
| Street Address: | Social Security Number: | Home Phone: Preferred |
| City: | State: | Zip Code: | Cell Phone: Preferred |
| Occupation: | Employer: | Employer Phone: Preferred |
| **Other Family Members seen here:** |
| Preferred Pharmacy: | Location: | Phone Number: |
| We make every effort to reach our patients in regards to their medical information. Gainesville Family Practice would like to insure that your medical information is properly protected as required by HIPAA guidelines. In the event that you are not available, please list names and phone numbers for those individuals with whom we may discuss your medical information. We will not leave messages containing sensitive health related information.1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **INSURANCE INFORMATION** |
| Person Responsible for Bill: | Birth Date: / /  | Address (if different than above): | Home Phone: |
| Is this person a patient here? Yes No  |
| Occupation: | Employer: | Employer Address: | Employer Phone: |
| **Name of Primary Insurance:** |
| Subscriber’s name: | Subscriber’s SSN: | Birth Date: / / | Member ID/ Policy #: | Group #: | Co-pay:$ |
| Patient Relationship to Subscriber: Self Spouse Child Other |
| **Name of Secondary Insurance** (If applicable): | Subscriber’s name: | Member/ Policy #: | Group #: |
| Patient Relationship to Subscriber: Self Spouse Child Other |
| **IN CASE OF EMERGENCY** |
| Name of local friend or relative: | Relationship to patient : | Home Phone: | Other Phone: |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Gainesville Family Practice or my insurance company to release any information required to process my claims.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Patient/ Guardian Signature Date* |