Pinehurst Family Care Center, PA

Adult Patient Registration Form

Last Name: _____ First Name: _____ Middle Name: _____

Name Preference: _____ Birth/Maiden Name: _____

Gender: _____ SSN: _____ Marital Status: _____ DOB: _____

Race: _____ Ethnicity: _____ Language Spoken: _____

Patient's Mailing Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Driver's License #: _____ Date Expired: _____ State of Issue: _____

Email Address: _____ May we contact you by email? _____

May we leave a message on your voicemail or answering machine? _____

Emergency Contact: _____ Phone No.: _____ Relationship: _____

Place of employment or school attending: _____

Insurance Company: _____ Policy Holder's Name: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Policy Holders Employer/Phone No.: _____

ID No.: _____ Group No.: _____

Other Insurance: _____ ID No.: _____ Group No.: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's SSN: _____ Policy Holder's Employer: _____

Guarantor Name: _____

Guarantor Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Place of Employment: _____ Full or Part-time: _____

May we contact you at work? _____

Please have your Insurance Card and a photo ID ready to photocopy with this Registration Form.

Authorization to Release Information

I authorize the release of any medical information necessary to process claims for service rendered by Pinehurst Family Care Center, PA. I permit a copy of this authorization to be used in the place of the original.

Date: _____ Signature (patient or responsible party): _____

Authorization to Bill Claim

I hereby authorize the providers of Pinehurst Family Care Center, PA to apply for benefits on my behalf for covered services rendered or ordered by them. I request that payment from my insurance company be made directly to the provider. I certify that the information I have reported with regards to my insurance coverage is correct. I permit a copy of this authorization to be used in place if the original.

Date: _____ Signature (patient or responsible party): _____

Acknowledgement Notice of Privacy Practice

I hereby acknowledge that I have received or been offered a copy to read of the Pinehurst Family Care Center, PA *Notice of Privacy Practices*.

Date: _____ Signature (patient or responsible party): _____