Lake Acworth Family Practice
MÉDICA CLÍNICA

REGISTRATION FORM

Today's date:	Primary Care Phyician:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Married / 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.:

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

Reason For this Visit: ❑ Illness ❑ Injury ❑ Job Related Injury ❑ Auto Accident ❑ Behavioral Health ❑ Other

_____

Major Complaint:

_____

Date of Injury or Onset of Problem :

How Do You Intend to pay For this Visit: ❑ Self-Pay ❑ Insurance **Mode of Payment** ❑ Cash ❑ Credit Card ❑ Check ❑ HSA

MEDICAL 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 ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]
❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

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

RESPONSIBLE PARTY (If 18 & under or someone other than patient is responsible for payment please complete this section.)

Name of Responsible Party: **Address if Different from Above:** **Relationship to Patient:**	Social Security #: Date of Birth	Phone Contacts:	Employed By: Work phone no.:

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 [Name of Practice] or insurance company to release any information required to process my claims.

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Patient/Guardian signature *Date*

IN CASE OF EMERGENCY

Name of local 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 authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*