Apple A Day Family Medicine

Patient Registration Form

PATIENT INFORMATION

Full Legal Name: _____ **Sex: M or F**
Last First Middle

Date of Birth: ___/_____/_____ Social Security #:_____Marital Status: _____

Local Address: _____
Street City State Zip

Billing Address (if different): _____
Street City State Zip

Home phone: (____) ____ -_____ Work phone: ( ) _____ Cell phone: ( )_____

Email address: _____

Employer/School Name and Phone: _____

Emergency Contact: _____ **Relation to contact:** _____
First Last

Emergency contact address: _____
Street City State Zip

Emergency contact phone: _____

GUARANTOR INFORMATION

(Please fill out if patient is a minor.)

Full Legal Name: _____ **Relation to Patient:**_____
Last First Middle

Mailing Address: _____
Street City State Zip

Sex: M F Employer/School: _____ **Work Phone: ( ) _____**

Home Phone: ( ) _____ **Social Security #:** _____ **DOB:** ___/____/____

Cell Phone: ( ) _____ **Email:** _____

INSURANCE INFORMATION (Please fill out completely and do not leave any blanks.)

Primary Insurance Company: _____ **Policy#/ID#**: _____ **Group #**:_____

Effective Date: _____ **Policy Holder**: _____ **Relationship to You**:_____

Policy Holder DOB: _____/____/_____ **Policy Holder Social Security #**: _____

Secondary Insurance Company: _____ **Policy#/ID#**: _____ **Group #**:_____

Effective Date: _____ **Policy Holder**: _____ **Relationship to You**: _____

Policy Holder DOB: _____/____/_____ **Policy Holder Social Security #**: _____

FINANCIAL AGREEMENT AND RELEASE OF INFORMATION

I request that payment of authorized Medicare or other insurance benefits are made payable directly to Apple A Day Family Medicine for any services furnished to me by Apple A Day Family Medicine. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid, its agents, the insurance company through which I am insured or covered, or any subsequent insurance companies from which I obtain coverage, any information needed to determine these benefits or the benefits payable for related services.

I have read Apple A Day Family Medicine's Financial Policy and agree to abide by its terms.

Signature of Patient or Legal Guardian: _____ **Date**: _____

Printed Name: _____ **Relationship to Patient**: _____