FirstChoice
Family Medicine

Patient Registration Form

Patient Information

Name:_____
First Middle Last

Date of Birth:_____ Sex ☐ Male ☐ Female

Social Security No:_____

Street Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____

Cell Phone:_____

Primary E-mail:_____

Occupation:_____Employer:_____

Emergency Contact Information

Name:_____
First Last

Relationship to Patient:_____

Home Phone:_____Work Phone:_____

Cell Phone:_____

E-mail:_____

How did you hear about us?

☐Friend ☐Internet Search ☐Zocdoc ☐honebook ☐nsurance Co ☐ther

☐
☐

Are you eligible for Medicare? ☐ Yes ☐ No

Consent for Treatment

I hearby give consent to the provider(s) and staff at FirstChoice Family Medicine to provide whatever treatment deemed necessary to the patient named above.

_____

Signature of Patient / Responsible Party Date

Release of Information

It is our office policy to NOT release any information regarding your medical history to anyone without your permission. This includes spouses & parents regardless of who is responsible for payment. If you want us to discuss your medical history with someone other than yourself, please list each individual below.

☐ I do not wish you to discuss my information with anyone besides myself.

☐ I do wish you to discuss my information with the following individual(s): _____

_____

_____

Signature of Patient / Responsible Party Date

Privacy Policy

I have had the opportunity to review and understand the "Notice of Privacy Practices" regarding the uses and disclosures of my health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), and I understand that I can obtain a copy at any time at http://www.cms.hhs.gov/hipaa. In accordance with this policy, FirstChoice Family Medicine, its provider(s) and staff, may leave detailed phone messages, send me reminders and emails related to my care.

_____

Signature of Patient / Responsible Party Date

Financial Policy

I have had the opportunity to review and understand the Financial Policy prior to receiving treatment. I hereby assign all medical benefits, to include major medical benefits to which I am entitled, to FirstChoice Family Medicine. I understand that I am financially responsible for all the charges whether or not covered by insurance at the time of service. If there is a balance due, my appointment or consultation may be rescheduled until the balance is paid in full. Any unpaid balance 60 days or older will be charged to the credit card on file. If my balance is still not paid in full, it may be turned over to a collection agency, at which time I agree to be responsible for collections charges and all associated legal fees in addition to the amount owed. I may also be dismissed from the practice.

_____

Signature of Patient / Responsible Party Date