Medical Park Family Care

**Patient Registration**

**CURRENT PATIENT INFORMATION**
**Please Print**
Last Name:_____
First Name:_____
Middle Name:_____
Address:_____
City:_____ State:____ Zip:_____
Last 4 of SSN:_____
Phone:_____
Work Phone:_____
Mobile Phone:_____
Sex:_____ Date of Birth:_____
Employer:_____
Patient email:_____

**GUARANTOR INFORMATION**
**(to whom statements are sent)**
Name:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Relationship to patient:_____
Date of Birth:_____
Home Phone:_____

**EMERGENCY CONTACT INFROMATION**
Name: _____
Relationship:_____
Phone: _____

**PRIMARY INSURANCE INFORMATION**
Insurance Plan Name:_____
Policy Holder Name: _____
Policy Holder Address: _____
City: _____ State: _____ Zip: _____
Policy Holder Date of Birth: _____
Employer Name: _____
Patient's relationship to policy holder: _____
ID/Certification No: _____
Policy/Group No: _____

**SECONDARY INSURANCE INFORMATION**
Secondary Plan Name:_____
Policy Holder Name: _____
Policy Holder Address: _____
City: _____ State: _____ Zip: _____
Policy Holder Date of Birth: _____
Employer Name: _____
Patient's relationship to policy holder: _____
ID/Certification No: _____

**ASSIGNMENT AND RELEASE:**
I hereby assign my insurance benefits to be paid directly to the physician.
I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
I authorize the physician to release any medication information required to process this claim.
I authorize my provider's office to contact me by telephone to remind me of my appointments.
A Fee for no shows may apply.
Signed_____ Date: _____