North Lincoln Family Medical Center

PATIENT REGISTRATION

TODAY'S DATE _____

NAME _____ DATE OF BIRTH _____

ADDRESS _____ SOCIAL SECURITY # _____

CITY _____ STATE _____ ZIP _____ SEX M F MARITAL STATUS S M D W

HOME PHONE _____ RACE CAUCASIAN AFRICAN AMERICAN HISPANIC

CELL PHONE _____ ASIAN OTHER _____

EMPLOYER _____ WORK PHONE _____

EMERGENCY CONTACT NAME & PHONE _____

IF MARRIED, SPOUSES NAME _____ SOCIAL SECURITY # _____

SPOUSES EMPLOYER _____ DATE OF BIRTH _____

GUARANTOR INFORMATION

Person responsible for bill. If same as patient, mark same.

NAME _____ RELATION TO PATIENT _____

ADDRESS _____ DATE OF BIRTH _____

CITY _____ STATE _____ ZIP _____ SOCIAL SECURITY # _____

EMPLOYER _____ PHONE _____ HOME PHONE _____

INSURANCE COVERAGE INFORMATION

Please be prepared to present your INSURANCE CARDS to the receptionist.

Primary Insurance

NAME _____

ADDRESS _____

POLICY # _____ GROUP # _____

POLICY HOLDER _____

RELATION TO PATIENT _____

Secondary Insurance

NAME _____

ADDRESS _____

POLICY # _____ GROUP # _____

POLICY HOLDER _____

RELATION TO PATIENT _____

INSURANCE AND ASSIGNMENT OF BENEFITS AUTHORIZATION INFORMATION

I hereby authorize treatment of the above named patient and agree to pay all charges for treatment regardless of insurance coverage or the pendency of insurance claims.

I authorize the release of all medical information to the above insurance carriers that is pertinent to my medical care and necessary to process my insurance claims. I will assign all medical and surgical benefits to North Lincoln Family Medical Center. A photocopy of this form shall be as valid as the original. I understand that I can withdraw this medical benefit assignment at any time by notifying this office in writing.

I HAVE READ THIS INFORMATION THOROUGHLY AND UNDERSTAND IT.

PATIENT SIGNATURE _____ DATE _____
(Parent or legal guardian if minor)

POLICYHOLDER SIGNATURE _____ DATE _____
(PRIMARY INSURANCE) (if different than Patient)

POLICYHOLDER SIGNATURE _____ DATE _____
(SECONDARY INSURANCE) (if different than Patient)