

FALLBROOK FAMILY HEALTH CENTER, LLC

PATIENT REGISTRATION

TODAY'S DATE _____

PATIENT INFORMATION

NAME _____

DATE OF BIRTH _____

ADDRESS _____

SOCIAL SECURITY # _____

CITY _____ STATE _____ ZIP _____

SEX M F MARITAL STATUS S M D W

HOME PHONE # _____

WORK PHONE # _____

EMPLOYER _____

OCCUPATION _____

E-MAIL ADDRESS _____

HOW DID YOU HEAR ABOUT US? _____

IF MARRIED, SPOUSES'S NAME _____

SOCIAL SECURITY # _____

SPOUSE'S 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 # _____

EMERGENCY CONTACT _____

PHONE _____

INSURANCE COVERAGE INFORMATION

PLEASE BE PREPARED TO PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST.

Primary Insurance

NAME _____

Secondary Insurance

NAME _____

ADDRESS _____

ADDRESS _____

POLICY # _____ GROUP # _____

POLICY # _____ GROUP # _____

SUBSCRIBER _____

SUBSCRIBER _____

RELATION TO PATIENT _____

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 Fallbrook Family Health Center, LLC. 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)

SUBSCRIBER SIGNATURE _____

DATE _____

(Primary Insurance) (if different from patient)

SUBSCRIBER SIGNATURE _____

DATE _____

(Secondary Insurance) (if different from patient)