WATERFORD FAMILY PHYSICIANS, P.C.

PATIENT REGISTRATION

Patient Name_____ Age: _____ Sex: _____ Birthdate: _____
LAST FIRST MIDDLE

Address: _____ City: _____ State: _____ Zip: _____

Phone Home: _____ Work: _____ Cell: _____

EMAIL Address: _____ _____ Marital Status: _____

Your SS#: _____ Your employer's name: _____ Your occupation: _____

Spouse Name: _____ Spouse's Emp: _____ _____ Bus. Phone: _ _____

Who can we reach in case of emergency? (Other than spouse) Name: _____ Phone: _____

Were you referred to our office? If so, how? Friend/relative Name: _____ _____Yellow Pgs: _____

Physician Referral: _____Other? _____

Are you allergic to any medications? If so give name of medications: _____

Do you have medical insurance? _____Yes _____ No If yes please fill out insurance information.

Name of insurance company? _____ Effective date of policy? _____ Insurance ID #: _____

Name of policyholder and relationship (If not patient) _____Policyholders SS#: _____

Policyholders Birthdate: (if other than patient) _____ Policyholders phone #:(if not same as patient): _____

If policyholder has a different address please give address: __

Policyholders Employer: _____Phone: _____

PLEASE COMPLETE IF PATIENT IS A MINOR Who is the patient's legal guardian? _____

Guardians SS#: _____ Guardians phone # (if different than patient) _____

Guardians address (if different than patient) _____

Who is responsible for payment of the account? _____ Relationship if any to pt.: _____

SS# of responsible party: _____ Employer of responsible party: _____ _____

======PLEASE GIVE INSURANCE CARD AND DRIVERS LICENSE TO RECEPTIONIST=======

ASSIGNMENT OF BENEFITS

I hereby assign all Medical and/or surgical benefits; including Major Medical Benefits, to which I am entitled, including Private Insurance, and any other Health Plan to the physicians of Waterford Family Physicians. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance. Hereby authorize said assignee to release all information necessary to secure payment.

Signed: _____ Date: _____

MEDICARE ASSIGNMENT

I (patient name) _____request that payment of authorized Medicare benefits be made on my behalf to the physicians of Waterford Family Physicians for any services furnished by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any Information needed to determine these benefits for related services.

Signed: _____ Date: _____