

# Family Medicine at Sterling Ridge

## Patient Registration Form

### Welcome to Our Practice!

Date \_\_\_\_\_ Patient \_\_\_\_\_  
Last Name First Name Initial

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Sex  M  F Age \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Business Phone: \_\_\_\_\_

Patient's Birth Date \_\_\_\_\_  Single  Married  Widowed

Social Security # \_\_\_\_\_

Responsible Party (if patient is a minor) \_\_\_\_\_

Patient (or parent if minor) employed by \_\_\_\_\_

Business Address \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Preferred Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

#### **With whom may we share information about your account?**

*(If you leave this blank then we will not share information with anyone, including spouse or family members)*

Name (s) \_\_\_\_\_

#### **In case of Emergency, Please list a person whom we may contact**

Name of Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Insurance Information**

Do you have Medical Insurance? \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Policy Holder's Phone \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Date of Birth (of Policy Holder) \_\_\_\_\_ Social Security # (of Policy Holder) \_\_\_\_\_

Name of Secondary Insurance Company (if any) \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Date of Birth (of Policy Holder) \_\_\_\_\_ Social Security # (of Policy Holder) \_\_\_\_\_

**Please tell us how were you referred to our practice?**

Friend/Relative, if so, name: \_\_\_\_\_

Yellow Pages  Physician, if so, name: \_\_\_\_\_

Postcard

Internet  Hospital referral  Other? \_\_\_\_\_

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with insurer).

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I have received notice of this organization's privacy policies.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_