



REGISTRATION FORM

Physician: _____ Office: _____

PATIENT INFORMATION					
Last Name		First Name		Middle Initial	Maiden Name
Address				City/State	Zip
DOB	Age	Relation to Responsible Party	SS#	Home Phone	Work Phone
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Employer Name & Address		Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Retired <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed	Cell Phone	E-Mail Address
Referring Physician			Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W	Patient Student Status <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time <input type="checkbox"/> Not a Student	
Name of siblings or other family members also coming to this practice:					
How did you hear about us? <input type="checkbox"/> Hospital Help Line <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Provider Directory <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor					
Other: Name: _____ May we thank them? <input type="checkbox"/> Yes <input type="checkbox"/> No					

<input type="checkbox"/> SAME AS PATIENT RESPONSIBLE PARTY INFORMATION (If Different from Patient) <i>For minor child, please indicate name of person giving consent for treatment</i>						
Last Name		First Name		Middle Initial	Maiden Name	Birthdate
Address			S.S.#	Home Phone	Cell Phone	Work Phone
City, State, Zip		Relationship to Patient		Employer Name & Address		
Spouse		Spouse Employer & Address			Spouse Work Phone	

EMERGENCY CONTACT			
Emergency Contact Name		Home Phone	Work Phone
Address, City, State & Zip		Other Phone	Relation to Patient

PRIMARY INSURANCE INFORMATION			
Insurance Company	Group#/Plan ID	Member Number	Copay Amount
Mail Claims to Address:	Group Name		Effective Date
Subscriber Employer Name & Address	Patient Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Subscriber Name & Address	Does your insurance require a referral to a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Subscriber DOB

SECONDARY INSURANCE INFORMATION			
Insurance Company	Group#/Plan ID	Member Number	Copay Amount
Mail Claims to Address:	Group Name		Effective Date
Subscriber Employer Name & Address	Patient Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Subscriber Name & Address	Does your insurance require a referral to a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Subscriber DOB

The undersigned patient or guardian certifies that the above facts are correct and agrees as follows:

1. Authority is granted to Health First Physicians to render needed treatment and/or tests to the above named patient.
2. I authorize Health First Physicians to release any information required for payment of claims.
3. I authorize my insurance or Medicare benefits to be paid directly to the treating physician, realizing I am responsible to pay noncovered and unauthorized service.
4. I understand that **I am responsible** for all charges incurred through Health First Physicians. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.
5. I have been given Health First Physician's handout on missed appointments and understand my responsibilities regarding being late or absent.

The above information is correct/Insured or Guardian Signature

Date