Family Medicine West

Patient Registration

→ **Name:** _____
Last *First* *Middle* *Maiden Name*

→ **Do you prefer to go by another name? If so, list it here:** _____

→ **Mailing Address:** _____

_____
City State Zip Code

→ **Phone:** _____ **Cell Phone:** _____ **Work:** _____

→ **Date of Birth:** _____ **Social Security #** _____

→ **Sex *(Circle your choice)*:** Male Female **Marital Status *(Circle your choice)*:** Single Married Divorced Widowed

→ **Ethnic Group *(Circle your choice)*:** American Indian or Alaska Native Asian Black or African American
Native Hawaiian or other Pacific Islander White Other ***(Please Specify)***: _____

→ *Do you have an Advance Directive (e.g., a living will or advance care plan)? (Circle)* ***Y N***

→ *Do you have a Power of Attorney? (Circle)* ***Y N***

********If YES to any of the above, please make sure we have a copy for your medical record********

INSURANCE INFORMATION

→ ***Primary Insurance*** _____ ***Secondary Insurance*** _____

→ **ID#** _____ **ID#** _____

→ **Group #** _____ **Group #** _____

→ **Insured** _____ **Insured** _____

→ **Insured's SSN** _____ **Insured's SSN** _____

→ **Insured's Date of Birth** _____ **Insured's Date of Birth** _____

→ **Pt's Relationship to Insured** _____ **Pt's Relationship to Insured** _____

→ ***Employer of Primary Insured*** _____ ***Employer #*** _____

**********IF THE PATIENT IS A MINOR: **********

→ **Who does the patient live with?** _____

→ **Relationship** _____ **D.O.B** _____

→ **Address** _____

→ **City** _____ **State** _____ **Zip** _____

→ **Custody Issues (Circle Choice)? Y N**

********If answered YES to the previous question, please provide documentation of custody********

EMERGENCY CONTACT

→ **In Case of Emergency Please Contact:** _____

→ **Phone:** _____ **Relationship:** _____

I hereby authorize Family Medicine West to furnish information to and obtain information from insurance carriers, healthcare providers and/or facilities concerning my illness and treatment. I hereby assign to FMW all payments for medical services provided to my dependents or me. I understand that I am responsible for any charges not covered by insurance, managed care, government or other provider. If my insurance refuses payment, I understand that I am responsible for all charges. I understand that further non-emergent care may be denied if my account is not paid.

→ _____ _____
Patient/ Guardian Signature Date