Cheney Ridge Family Medical Clinic
Patient Registration

First:_____ Middle Initial:_____ Last:_____ Date:_____

Maiden Name:_____ Nick Name:_____Age:_____ Date of Birth:_____

Street Address:_____Apt: _____

City:_____State:_____ Zip Code:_____

Home Phone:_____Cell Phone:_____ Email:_____

Social Security #:_____-_____-_____ Gender (Circle One) Male Female

Marital Status: (Circle One): Married Single Widowed Divorced

Emergency Contact(s) List name, phone# & relationship to patient:_____

Ok to release information to this person (Circle One) Yes No

Pharmacy (List Name and Address):_____

How do you get your supply of meds (Circle One): Monthly Every 3 months Every 6 months

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Primary Insurance:

Responsible Party: _____Subscriber:_____ Plan Start Date _____/ _____/ _____

Insurance Company:_____ Insurance Company Address:_____

Subscriber Name: _____ Group Number: _____Member Number: _____

Secondary Insurance:

Responsible Party: _____Subscriber:_____ Plan Start Date _____/ _____/ _____

Insurance Company:_____ Insurance Company Address:_____

Subscriber Name: _____ Group Number: _____Member Number: _____

Employer:

Name:_____ Occupation: _____

Work Address: _____City: _____ State: _____

Work Phone Address: (_____)_____ Ext: _____

I authorize direct payment of medical benefits and/or private insurance benefits on my behalf for any services furnished to me by Cheney Ridge Family Medical Clinic to be submitted directly to their office. I authorize the release of any medical information necessary to coordinate care with other physicians and to process claims. I understand that I am financially responsible for all charges whether or not paid by my insurance company. More and more insurance companies are requiring preauthorization for office visits, referrals and testing. Therefore, it is necessary for our patients to be responsible for checking with their insurance company for specific requirements of their plan.

I hereby authorize Cheney Ridge Family Medical Clinic providers or staff to leave information regarding my Protected Health Information (PHI) or my Treatment, Payment, or Operation Information (TPO) on my answering machine or voice mail.

I have been given information to read and review about the Health Insurance Portability and Accountability Act (HIPPA) which notifies me about protecting the privacy of my health information

Patient, Legal Guardian, or Power of Attorney Signature: _____