

FAMILY MEDICINE OF PORT ANGELES

PATIENT REGISTRATION

Please provide your insurance card and identification such as a driver's license or social security card for the receptionist to copy.

New Patient
File Update

Please print and complete all sections.

PATIENT'S NAME		FIRST	MIDDLE	LAST
STREET ADDRESS			CITY	STATE ZIP
MAILING ADDRESS (IF DIFFERENT THAN ABOVE)			CITY	STATE ZIP
HOME TELEPHONE	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
EMPLOYER			EMPLOYER TELEPHONE	
EMPLOYER ADDRESS				
LIST ALL MEMBERS OF IMMEDIATE FAMILY				
LANGUAGE LIMITATIONS?				
EMAIL ADDRESS				
EMERGENCY CONTACT: NAME		ADDRESS	TELEPHONE	RELATIONSHIP
NEAREST RELATIVE NOT LIVING WITH YOU: NAME		ADDRESS	TELEPHONE	RELATIONSHIP
REFERRED BY:				
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (IF DIFFERENT THAN ABOVE)		NAME – FIRST/MIDDLE/LAST		RELATIONSHIP
STREET ADDRESS			CITY	STATE ZIP
MAILING ADDRESS (IF DIFFERENT THAN ABOVE)			CITY	STATE ZIP
HOME TELEPHONE	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
EMPLOYER			EMPLOYER TELEPHONE	
SPOUSE'S NAME		DATE OF BIRTH	SOCIAL SECURITY NUMBER	
SPOUSE'S EMPLOYER			EMPLOYER TELEPHONE	
<p>I hereby authorize Family Medicine of Port Angeles to furnish my insurance company all the information needed to process any charges incurred by me. I authorize my insurance company to pay the physician directly for services rendered. I understand that I am financially responsible for all charges incurred by me, whether my insurance company pays or not. I further agree that in the event of nonpayment, I will bear the cost of collection and/or legal fees. I agree that a photocopy of this authorization shall be as valid as the original.</p>				
SIGNATURE				DATE
IF PATIENT IS A MINOR (UNDER 18 YEARS OF AGE) THE SIGNATURE BELOW AUTHORIZES TREATMENT AND RELEASE OF INFORMATION				
SIGNATURE		RELATIONSHIP	DATE	