

PATIENT REGISTRATION FORM (PLEASE PRINT)

Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

Permission to leave message on voice mail: Yes No Preferred # to Call: _____

Social Security #: _____ Sex: M F Place of Birth: _____

Employer: _____ Type of Job: _____

Marital Status: Single Married Other Work Status: Employed Student Homemaker
 Other: _____

INSURANCE INFORMATION (PLEASE PRINT)

Insurance Co: _____	Policy #: _____
Address: _____	Group #: _____
_____	Phone #: _____
Name of Subscriber: _____	<input type="checkbox"/> Check if Same as Patient
Subscriber Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Date of Birth of Subscriber: ____/____/____	SSN of Subscriber: _____
Employer of Subscriber: _____	
IF PATIENT IS MINOR; Name of Parent Signing this Form: _____	

Current Specialist and/or Prior Providers Name(s), Address, Phone Number

1. _____
2. _____

Person to Contact in Case of Emergency (Name, Relationship, Contact #):

How did you hear about us? Yellow Pages Ad Friend/Patient Other _____

I agree to be responsible for my medical expenses (including expenses not covered by my insurance company) and authorize the provider in charge to administer medical care as deemed necessary. I authorize the office of North Raleigh Family Medicine, to release my medical record(s) to my insurance company and to the North Carolina Office of Insurance and other government agencies for the purpose of processing my claim(s).

Signature: _____ Date: ____/____/____

Signature of Patient, Parent, or Legal Guardian