PATIENT REGISTRATION FORM

Patient Information

Date ____________

Last Name ______________________ First Name ______________________ Middle _____

Title ____________ Preferred Name/Nickname ______________ Birth Date __________ Sex M F

SSN ______________________ Marital Status ______________________

Address ____________________ City ______________ State _____ Zip __________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

DAYTIME PHONE ______________ Email Address ______________________

Local Emergency Contact Name ______________________________

Emergency Daytime Telephone Number ______________________________

Occupation ______________ Who referred you to our office? ______________

Responsible Party

Last Name ______________________ First Name ______________ Middle __________

Address ____________________ City ______________ State _____ Zip __________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Insurance Information

Primary Insurance Company ______________________________

Policy Holder ______________________ Relationship to Pt ______________

Policy Holder's DOB ______________ Policy Holder's SSN ______________________

Do you have a Secondary Insurance Company ________ Yes ________ No

Authorization to Release Information I hereby authorize Urban Family Practice to release my information acquired in the course of examination or treatment. (For Insurance/Medicare Purposes)

Signature ______________________

Authorization to Pay Benefits to Physician I hereby assign payment directly to Urban Family Practice for services covered by Insurance/Medicare. I understand that I am personally responsible for all charges and payment in full is due no later than 90 days from the date of service. Signature ______________________

Authorization for Treatment of Self & Minors I give consent for myself/son/daughter to undergo examination, lab-work, x-ray and treatment by Urban Family Practice. Signature ______________________

Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy. By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Signature ______________________________ Date ______________

Fees for services are payable at the time service is rendered. We will be happy to discuss fees with you in the office. We charge for missed appointments without 24 hr. cancellation. Cancellation notice must be made during regular office hours. It is your responsibility to be aware of coverage limits within your insurance plan. If you are not satisfied with payment on a claim, contact your insurance company.

PLEASE VERIFY INFORMATION IS CORRECT ANNUALLY. IF ALL INFORMATION IS THE SAME, DATE AND INITIAL BELOW, IF INFORMATION HAS CHANGED, PLEASE COMPLATE A NEW FORM

______________________ INITIALS/DATE

______________________ INITIALS/DATE