

## Patient Registration Information

Please PRINT AND complete ALL sections below!

### PATIENT'S INFORMATION

Marital Status  Single  Married  Divorced  Widowed Sex:  Male  Female

Name: \_\_\_\_\_  
Last name First Name initial

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ EMAIL Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Other: \_\_\_\_\_

Name: \_\_\_\_\_  
Last name First Name initial

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Please present insurance cards to receptionist.

PRIMARY Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Name of insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to insured:  
 Self  Spouse  
 Child  Other

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Copay: \$ \_\_\_\_\_

SECONDARY Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Name of insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to insured:  
 Self  Spouse  
 Child  Other

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Copay: \$ \_\_\_\_\_

### PAST MEDICAL RECORDS (Prior Primary Care Doctor)

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

### PHARMACY INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

### Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Winter Park Family Health Center, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: \_\_\_\_\_ Your Signature: \_\_\_\_\_