CHURCHVILLE-CHILI FAMILY MEDICINE LLC

PATIENT REGISTRATION FORM

Name (Last, First, Middle Initial)____

Date ______________ Home Phone (_____)_____________ Social Security # ____________________

Cell Phone# (_____)______________________ Sex M______ F______ Age________

Address______________________________________City_______________State ______ Zip ______

Birthdate________________ Single_____ Married_____ Widowed_____ Separated_____ Divorced_____

Patient Employed by____________________________________ Occupation ___________________

Business Address ______________________________________Business Phone__________________

In case of emergency who should be notified?_____________________________ Phone____________

Whom may we thank for referring you? ____

Proof of Insurance: All patients must complete the following section. We must obtain a copy of your current valid insurance card to provide proof of insurance. **If you fail to provide us with the correct insurance information in time to meet your insurance company claim filing limit, you will be responsible for the balance of the claim.**

Primary Insurance____

Group # ___________________Subscriber # ______________________Contract # __________________

Person Responsible for Account ____

Birthdate _____________ Social Security # __________________Relation to Patient __________________

Address (if different from patient's)____

City___________________________ State___________ Zip__________ Phone__________________

Person Responsible Employed by _________________________________ Occupation________________

Business Address_____________________________________ Business Phone ____________________

Is Patient Covered by Additional Insurance? Yes ____ No ____ Insurance Company ___________________

Group #__________________ Subscriber # ___________________ Contract #_____________________

Subscriber Name ______________________________ Relation to Patient __________ Birthdate__________

Address ____ Phone _____________ Social Sec #____________

I, the undersigned certify that I (or my dependent) have insurance coverage with the above named insurance and assign directly to Churchville-Chili Family Medicine LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In the event that Churchville-Chili Family Medicine LLC pursues civil remedies against me for the collection of my financial obligations for services rendered to me, I hereby agree to be responsible for reasonable collection, billing, and/or attorney fees and disbursements incurred by Churchville-Chili Family Medicine LLC. I have been given the opportunity to read the Churchville-Chili Family Medicine LLC HIPAA Notice of Patient Information Privacy Practices.

Signed ____ Date ______________________