Patient Registration

(make changes on this form and return to the receptionist – Thank You)

PATIENT INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security #:**
City:	**Sex:**
State: Zip:	**Marital Status:**
Home Phone #:	**Work Phone #:**
Cell Phone#:	**Email:**
Language Preference:	**Hispanic/Latino (Y/N)?:**
Hearing Impaired (Y/N)?:	**Vision Impaired (Y/N)?:**
Emergency Contact: **Name: _____** **Home #:_____** **Work #:_____** **Cell #: _____** **Relationship:**	**Race (American Indian/Alaskan Native, Asian, Black/African American, Native Hawaiian, Pacific Islander, White, More than 1):**
GYN:	

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security #:**
Address Two:	**Home Phone #:**
City:	**Work Phone #:**
State: Zip:	**Cell Phone #:**

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate #:	**Certificate #:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Copay:	**Copay:**
Subscriber Name:	**Subscriber Name:**

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Farmingdale Family Practice when he accepts assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, Farmingdale Family Practice to release any information necessary for my course of treatment.

Advance Beneficiary Notice. I am fully aware that certain procedures and immunizations are sometimes considered not medically necessary by insurance companies. Therefore, I give informed consent to have the designated procedure performed or immunization given and I am fully aware that this may be my full financial responsibility.

_____ _____

Signed (patient or parent if minor) Date