

# FALLBROOK FAMILY HEALTH CENTER, LLC

## PATIENT REGISTRATION

TODAY'S DATE \_\_\_\_\_

FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_ LAST NAME \_\_\_\_\_  
PREFERRED NAME (if different than legal name) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ GENDER \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_ MARITAL STATUS Single Married Divorced Widowed Other \_\_\_\_\_  
RACE: WHITE BLACK AM INDIAN/ESKIMO/ALEUT HISPANIC ASIAN/PACIFIC ISLANDER OTHER  
ETHNICITY: HISPANIC/LATINO NOT HISPANIC/LATINO LANGUAGE: ENGLISH SPANISH OTHER  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE # \_\_\_\_\_ WORK PHONE # \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_ HOW RELATED? \_\_\_\_\_  
E-MAIL ADDRESS \_\_\_\_\_ HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

IF MARRIED, SPOUSES'S NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
SPOUSE'S EMPLOYER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

### PERSON RESPONSIBLE FOR BILL. IF SAME AS PATIENT, CHECK SAME HERE

NAME \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_  
ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_ HOME PHONE # \_\_\_\_\_

### INSURANCE COVERAGE INFORMATION PLEASE BE PREPARED TO PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST.

If you have already provided us with a copy of your insurance card, please check HERE

Primary Insurance	Secondary Insurance
NAME _____	NAME _____
ADDRESS _____	ADDRESS _____
POLICY # _____ GROUP # _____	POLICY # _____ GROUP # _____
SUBSCRIBER _____	SUBSCRIBER _____
RELATION TO PATIENT _____	RELATION TO PATIENT _____

### INSURANCE AND ASSIGNMENT OF BENEFITS AUTHORIZATION INFORMATION

I hereby authorize treatment of the above-named patient and agree to pay all charges for treatment regardless of insurance coverage or the pendency of insurance claims.

I authorize the release of all medical information to the above insurance carriers that is pertinent to my medical care and necessary to process my insurance claims. I will assign all medical and surgical benefits to Fallbrook Family Health Center, LLC. A photocopy of this form shall be as valid as the original. I understand that I can withdraw this medical benefit assignment at any time by notifying this office in writing.

**I HAVE READ THIS INFORMATION THOROUGHLY AND UNDERSTAND IT.**

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(Parent or legal guardian if minor)  
SUBSCRIBER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(Primary Insurance) (if different from patient)  
SUBSCRIBER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(Secondary Insurance) (if different from patient)