FALLBROOK FAMILY HEALTH CENTER, LLC

PATIENT REGISTRATION **TODAY'S DATE ____________________**

PATIENT INFORMATION

NAME ____ DATE OF BIRTH _________________________________

SOCIAL SECURITY # _____________________________ SEX M F MARITAL STATUS S M D W

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 ____

E-MAIL ADDRESS _________________________________ HOW DID YOU HEAR ABOUT US?______________________

IF MARRIED, SPOUSES'S NAME ______________________ SOCIAL SECURITY # ______________________________

SPOUSE'S EMPLOYER ______________________________ DATE OF BIRTH _________________________________

GUARANTOR INFORMATION

PERSON RESPONSIBLE FOR BILL. IF SAME AS PATIENT, MARK SAME.

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.

Primary Insurance

NAME ____

ADDRESS ____

POLICY # _________________ GROUP # ______________

SUBSCRIBER _____________________________________

RELATION TO PATIENT _____________________________

Secondary Insurance

NAME ____

ADDRESS ____

POLICY # _________________ GROUP # ______________

SUBSCRIBER _____________________________________

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)

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