

- PATIENT REGISTRATION -

FAMILY WELLNESS CENTER

_____ **New Pt.**

_____ **Updated Pt. Info**

Patient Last Name	First	MI	Occupation	Work Tel#
Mailing Address	Apt or Unit #		Employer's Name	
City ()	State	Zip	Company Address	
Home Telephone M-S-D-W	Date of Birth M-F		City	State
Age	Marital Status (circle)	Sex (circle)	Social Security#	Last Name of FAMILY PHYSICIAN
				First
				MI
GUARANTOR NAME-Person to Bill if Other Than Patient			Street Address	
Mailing Address	Apt or Unit #		City	State
City	State	Zip	Physician's Telephone	
How did you hear about our practice? : Yellow Pages Friend Referring Physician Radio Other: _____				
EXTENDED AUTHORIZATION AND CONSENT				
I request that payment under the medical insurance program be made directly to the named provider on any unpaid bills for services provided on or after the date indicated below. I authorize any holder of medical or other information about me to release to the Social Security Administration, it's intermediaries or carriers of insurance companies, any information needed for this or a related Medicare or insurance claim. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to obtain necessary referral and/or other authorizations from my primary care and/or referring physician when required. I permit a copy of this authorization to be used in place of the original.				
Signature of Patient or Authorized Representative: _____			Date: _____	

Primary Insurance Information
(Please attach a copy of Ins. Card)

Patient's Relationship to the Insured: Self Spouse Child Other

Subscribers Name _____ Date of Birth _____

Subscribers ID# _____ Co-Pay for OV _____

Ins. Company Name _____

Ins. Co. Address _____

City _____ State _____ Zip _____

Secondary Insurance Information
(Please attach a copy of Ins. Card)

Patient's Relationship to the Insured: Self Spouse Child Other

Subscribers Name _____ Date of Birth _____

Subscribers ID# _____ Co-Pay for OV _____

Ins. Company Name _____

Ins. Co. Address _____

City _____ State _____ Zip _____