Patient Registration Information

Please print and complete all sections below

Patient's Personal Information: Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Race: American Indian-Alaska Native-Asian-Black/African American-Native Hawaiian-White-Pacific Islander-More than one race-Refuse to report

Ethnicity: Hispanic or Latino---Not Hispanic or Latino---Refuse to report/unreported

Preferred Language: English---Spanish---Other

Name: _____

Last Name First Name M. Initial

Date of Birth _____/_____/_____ Social Security #: _____ - _____ - _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Address: _____ City: _____ State:_____ Zip:_____

Driver's License # _____ State issued: _____ Email Address: _____

Guarantor of Account Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other _____

Name: _____ Date of Birth _____/_____/_____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Employment Information: ☐ Full Time ☐ Part Time ☐ Retired ☐ Full Time Student ☐ Part Time Student

Employer: _____ Occupation: _____

Work Phone: (_____)_____ Address: _____

Insurance Information: Please present insurance cards to receptionist.

Primary Insurance Name: _____

Group # _____ Policy # _____ Copay $_____

Name of cardholder: _____ Date of Birth _____/_____/_____ SS # _____-_____-_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Secondary Insurance Name: _____

Group # _____ Policy # _____ Copay $_____

Name of cardholder: _____ Date of Birth _____/_____/_____ SS # _____-_____-_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

How were you referred to EFCS ___ Television_____ Website_____ Social Media/Facebook/Twitter_____

Family/Friend____ Magazine____ Word of Mouth____ Walk-In____ Other, Please Explain_____

Emergency Contact:

Name: _____ Relationship: _____

Address:_____ City: _____ State:_____ Zip:_____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Emmanuel Family Clinic, and any assisting physicians for services needed. I understand that I am financially responsible for all charges whether of not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Submit

_____ _____

Signature Date