**Roman Family Practice, PLLC PATIENT REGISTRATION FORM**

**Please complete ALL fields in print. \*How did you hear about us**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PATIENT INFORMATION** | | | | | | | | | | | |
| **Name**: LAST FIRST M.I. | | | | | | | | | **Gender**  Male 🞏  Female 🞏 | | |
| **Date of Birth:** | **Patient Email:** | | | | | | | | | | |
| **Address**: | | | **City**: | | | | **State**: | | | **Zip Code**: | |
| **Phone Number**  ( ) - | | | **Social Security Number:** | | | | | | | | |
| **PRIMARY INSURANCE & SUBSCRIBER INFORMATION** | | | | | | | | | | | |
| **Primary Insurance Name:** | | | **Relationship to Subscriber:** | | | | | | | | |
| **Subscriber’s Name**: LAST FIRST M.I. | | | | **Subscriber’s Date of Birth**  / / | | | | | | | |
| **Subscriber ID #** | | **Group #** | | | | **Plan #** | | | | | **Pharmacy #** |
| **SECONDARY INSURANCE** | | | | | | | | | | | |
| **Secondary Insurance Name:** | | | **Relationship to Subscriber:** | | | | | | | | |
| **Subscriber’s Name**: LAST FIRST M.I. | | | | | **Subscriber’s Date of Birth**  / / | | | | | | |
| **Subscriber ID #** | | | **Group #** | | | **Plan #** | | | | | **Pharmacy #** |
| **EMERGENCY CONTACT AND RELEASE OF INFORMATION** | | | | | | | | | | | |
| **Emergency Contact:** | | | **Relationship to Patient:** | | | | | Phone No.: | | | |
| **\***If patient is a child, who may authorize treatment for this child? | | | **\***Relationship to Patient: | | | | | Phone No.:  ( ) - | | | |
| Do you have a telephone answering machine or voicemail in your home? Yes 🞏 No 🞏  If so, may we leave messages from this office on that machine? Yes 🞏 No 🞏 | | | | | | | | | | | |
| Do you authorize release of your medical information to anyone besides your insurance carrier(s)? Yes 🞏 No 🞏  If so, whom? | | | | | | | | | | | |

I authorize Roman Family Practice, PLLC, or its representative, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Tricare, private insurance, and any other health plan to Roman Family Practice, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. An authorized signature is on file below. By signing, I attest that all information provided is true and complete and that my injury/illness is not work related. The responsible party is billed for appointments un-kept or cancelled with less than 24 hour’s notice. I understand that I will be assessed the bank charge for each check returned due to insufficient funds. In the event of default, I (We) promise to pay legal interest on the indebtness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note. I hereby authorize Roman Family Practice, PLLC to release all information necessary to secure payment and treatment.

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\*\* All co-pays are due at time of service.

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**Patient, Parent or Guardian’s Signature** **Date**