Unifour Family Practice Patient Registration/Update Form

PRINT

Patient Name:_____**Date of Birth**:_____ **Age**:_____

Social Security #_____**Drivers License #**_____ **Gender:** M ◯ F ◉ **Race**: _____

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated **Language:** _____ **Ethnicity:** ◯ Hispanic ◯ Non Hispanic

Mailing Address: (Street) _____ **(City)**_____**(State)**_____**(Zip Code)**_____

Home Phone# (_____)_____**Cell Phone#** (_____)_____ **Work #** (_____)_____

Employer: _____ **Occupation:** _____

Spouse's Information: Name: _____ Employer: _____

Occupation: _____ Work # (_____) _____

Name of parents/guardians (only if patient is under 18 years of age): _____

Student: ◯ Yes ◯ No School Name: _____

EMERGENCY CONTACT: **Please list someone over 18 yrs of age.**

Name _____Relationship _____Phone# (_____)_____

Responsible Party/Billing Information: (if different from patient) (Parent/guardian) (Not insurance carrier)

Full Name: _____Social Security # _____ Date of Birth _____

Address: (Street) _____ (City) _____(State) _____ (Zip Code) _____

Relation to patient: _____ Phone#(_____)_____ Cell#(_____)_____

Employer Name: _____ Employer Phone # (_____)_____

Insurance Information:

Primary Insurance Company: _____Subscriber ID #_____Group#_____

Insured's Name: _____Date of Birth_____ Social Security #_____ Phone# _____

Insured's Employer: _____Relation to patient _____

Secondary Insurance Company: _____ Subscriber ID #_____ Group#_____

Insured's Name: _____ Date of Birth _____ Social Security #_____Phone# _____

Insured's Employer: _____ Relation to patient _____

New Patient Appointment Policy: In order to schedule a new patient appointment we require a $50.00 deposit at time of scheduling appointment.

Cancellation Policy: I am aware of the cancellation policy. I understand that a **$28.00 charge** (subject to change) will be put through on my account if I fail to give 24 hours notice to cancel an appointment. Same day appointments are subject to this policy as well.

Assignment of Insurance Benefits: I hereby authorize direct payment of medical benefits to Unifour Family Practice for services rendered. I understand that I am financially responsible for any balance not covered by insurance. I understand that certain procedures are not covered under routine office visits and may go towards my deductible depending upon my insurance plan.

Authorization to Release Information: I hereby authorize Unifour Family Practice to release any medical information that may be necessary for continued medical care with another provider or the processing by my insurance company for a medical claim.

Consent to HIV/HBV Testing: I hereby authorize Unifour Family Practice to order the performance of blood tests to determine the presence or absence of antibodies of the HIV and HBV in my blood if during my care a healthcare provider is directly exposed to my blood or bodily fluids in a manner which may transmit this disease.

PATIENT/GUARDIAN NAME: (Please Print) _____

PATIENT/GUARDIAN SIGNATURE: _____**DATE**: _____

PRINT