Frontier Family Medicine

Board Certified

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Patient Registration

Last Name________________________________First Name and Middle Initial____________________________

Social Security Number_________________ _____________Marital Status: ○ Single ○ Married

Mailing Address____________________________ __________City ____________ State__________ Zip_________

Physical Address_____________________________________ City____________ State __________Zip_________

Date of Birth____________ Gender: ○ Male ○ Female

Cell Phone________________________Home Phone___________________ Work Phone____________________

Employer Name______________________ Address_____________________________________Zip__________

EMERGENCY CONTACT NAME:___________________PHONE_____________RELATIONSHIP___________

SPOUSE INFORMATION

Spouse Name ____

Social Security Number________________________ Date of Birth_______________________________________

Employer_____________________________ Employer Phone Number_________________________________

Employer Address____

RESPONSIBLE PARTY- (for parents or legal guardians)

(Please note that the parent signing the bottom of this page is the responsible party).

Last Name_______________________________________ First Name and Initial_________________________

Social Security Number____________________ Date of Birth____________________________________

Mailing Address____City_____________ State________ Zip_____

Physical Address____City_____________State________Zip_____

Employer Name______________________________________ Employer Phone__________________________

Employer Address____

PRIMARY INSURANCE INFORMATION

Insurance Company Name__________________________ Phone Number_________________________________

Claim Address____

Policyholder's Full Name______________________________ Relationship to Patient______________________

ID or Subscriber Number______________________________ Policyholder's Date of Birth___________________

SECONDARY INSURANCE INFORMATION

Insurance Company Name__________________________ Phone Number_________________________________

Claim Address____

Policyholder's Full Name______________________________ Relationship to Patient______________________

ID or Subscriber Number______________________________ Policyholder's Date of Birth___________________

Signature of Responsibility

I understand and agree that I am claiming responsibility to pay ALL fees and charges for treatment of the person named above (regardless of insurance) unless I inform you otherwise in writing. I agree to pay all charges for me and members of my family when services are rendered. In the event legal action is necessary to collect any unpaid charges, I agree to pay costs of collections, including attorney's fees. It is agreed that payments will not be delayed or withheld because of my insurance coverage or the pending of claims thereon, and all proceeds of insurance are assigned to this office. Unless otherwise paid, but without the office assuming any responsibility for the collection thereof. (A copy of this assignment is as valid as the original). I understand that all charges are payable at the time of service regardless of insurance and any charges allowed pending insurance is at the sole discretion of Frontier Family Medicine and subject to 10% interest monthly. I understand that the doctorsøtime is valuable and by õno showingö any appointments it is taking away from others that need to get into the doctor. I understand I am required to call the office before my agreed appointment time to cancel and if I donøt call in before the appointment there is a $50.00 charge for each no show. By my signature below, I understand, agree with the above and acknowledge that Frontier Family Medicine has made available its "Notice of Privacy Practices" for me to review and that I may request a copy if I so desire.

Consent/Release: The undersigned hereby authorizes this clinic to release appropriate information to the patient's referring doctor and/or health and/or government agency and/or insurance company and/or professional consultant selected by the physicians of this clinic. I certify this information is true and correct to the best of my knowledge. I understand that I may be charged a fee for copying such records. I will notify this clinic of any changes in my health status of the above information.

Signature____ Date____________________________

Parent or Guardian (if minor) ____