

PATIENT REGISTRATION FORM
PLEASE PRINT CLEARLY

Patient:

Last Name _____ First _____ Middle Initial _____ Sr. Jr. II III _____

Date of Birth ____ - ____ - ____ Social Security # ____ - ____ - ____ Gender: M /F

Marital Status: **(Circle One)** Single Married Divorced Widowed

Mailing Address _____ Apt _____ lot _____ PO Box # _____

City _____ State _____ Zip Code _____

Telephone #'s – Please check preferred

Home # (____) ____ - ____ Work # (____) ____ - ____

Cell # (____) ____ - ____ Other # (____) ____ - ____

Family Doctor _____ **City** _____

How were you referred to our office? _____

***Would you be interested in receiving information about Advanced Directives?** Y/ N

INSURANCE CARRIER OR PARENT *(COMPLETE ONLY IF DIFFERENT FROM PT)*

Last Name: _____ First _____ Middle Initial _____

Gender: M/ F Date of Birth ____ - ____ - ____ Social Security # ____ - ____ - ____

Relationship to Patient _____

Mailing Address _____ Apt _____ lot _____ PO Box # _____

City _____ State _____ Zip Code _____

Phone # (____) ____ - ____ Employer _____

PRIMARY INSURANCE

Insurance Name _____ Policy Holder _____ Copay \$ _____

Policy Holder's Social Security # ____ - ____ - ____ **Relationship to patient** _____

Policy Holder's Date of Birth ____ - ____ - ____ **Gender: M/ F**

SECONDARY INSURANCE

Insurance Name _____ Policy Holder _____ Copay \$ _____

Policy Holder's Social Security # ____ - ____ - ____ **Relationship to patient** _____

Policy Holder's Date of Birth ____ - ____ - ____ **Gender: M/ F**

I, the undersigned, a patient of Lapeer Family and Urgent Care, do hereby authorize physicians and staff of Lapeer Family and Urgent Care to administer treatment as is necessary. I understand as a courtesy Lapeer Family and Urgent Care will prepare insurance forms and bill my insurance company directly. I hereby request assignment of payment of all insurance benefits to Lapeer Family and Urgent Care. I am ultimately responsible for all services rendered, unless otherwise provided by law.

Patient/Parent or Guardian Signature: X _____ **Date** _____

NOTICE OF PAYMENT RESPONSIBILITY

Lapeer Family & Urgent Care participates with many insurance companies. However, if you have a plan in which we are not a provider or have a co-pay through your insurance, you are ultimately responsible for any charges incurred from your visit. It is your responsibility to know the limitations of your coverage and what your benefits include. Those without insurance acknowledge responsibility for charges incurred from services rendered.

I understand that it is my responsibility to pay any office calls, co-pays or services not covered by my insurance. I understand that failure to do so will result in discharge from doctor's care.

Signature_____

Date_____

RELEASE OF CONFIDENTIALITY

I, _____, understand that by signing this document I am

NAME

allowing any trained employee by Lapeer Family & Urgent Care to reveal information in **my**/ my child's (if patient is a minor) chart to:

_____, _____
Name Relationship

_____, _____
Name Relationship

I will not hold Lapeer Family & Urgent Care responsible for releasing information in **my**/ my child's (if patient is a minor) chart pertaining to test results, medications, consultations or any other related items to the above named person. By signing this I also understand that I will not be notified before any information is released and that I do give permission for Lapeer Family & Urgent Care to speak to the person named above about my medical condition or medical records. If the above spaces are left blank, I acknowledge that the staff of Lapeer Family & Urgent Care will not release any personal medical information to anyone but the patient **OR** if the patient is a minor, information is automatically given to their **biological parents**.

Patient OR Parent Signature _____
Date

EMERGENCY CONTACTS

1. Full Name: _____ Relationship to Patient _____
Mailing Address _____ Apt _____ lot _____ PO Box # _____
City _____ State _____ Zip Code _____
Home # (_____) _____ - _____ Cell # (_____) _____ - _____

2. Full Name: _____ Relationship to Patient _____
Mailing Address _____ Apt _____ lot _____ PO Box # _____
City _____ State _____ Zip Code _____
Home # (_____) _____ - _____ Cell # (_____) _____ - _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name _____ Birth date _____
(Printed)

Signature _____

Date _____