# Patient Registration Information

Please PRINT AND complete ALL section below

## PATIENT'S PERSONAL INFORMATION

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: ____ / ____ / ____ Social Security # ____ ~ ____ ~ ____

Home Phone: (____)____ Work Phone: (____)____ Cell Phone: (____)____

Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

E-MAIL Address: _____

## PATIENT'S RESPONSIBLE PARTY INFORMATION

**Relationship to Patient:** Self Spouse Parent Other: _____

* If Self, Circle and move to next section.

**Marital Status:** Single Married Divorced Widowed

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: ____ / ____ / ____ Social Security ____ ~ ____ ~ ____

Home Phone: (____)____ Work Phone: (____)____ Cell Phone: (____)____

Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

## PATIENT'S INSURANCE INFORMATION

Please present insurance card to receptionist

PRIMARY Insurance Name: _____

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

Policy #: _____ Group #: _____ Copay: $_____

Name of insured: _____ Date of Birth: _____ Patient's relationship to insured: Self Child Spouse Other

Insured person's Employer: _____ Marital Status: Singal Married Divorced Widowed

SECONDARY Insurance Name: _____

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

Policy #: _____ Group#: _____ Copay: $_____

Name of insured: _____ Date of Birth: _____ Patient's relationship to insured: Self Child Spouse Other

Insured person's Employer: _____ Marital Status: Singal Married Divorced Widowed

## PATIENT PRIMARY CARE PHYSICIAN

Name: _____

Address: _____ City: _____ State: _____ zip: _____

Phone: (____)____ Fax: (____)____

## Emergency Contact

Name: _____ Relationship: _____

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

Home Phone (____)____ Work Phone:(____)____ Cell Phone:(____)____

## Assignment of Benefits * Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to Village Health Urgent & Family Care, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or 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 valis as the original.

Date: _____ Your Signature _____