

# KERNERSVILLE PRIMARY CARE REGISTRATION FORM

(Please Print)

Today's date:	E- Mail address :
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## PATIENT INFORMATION

Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Social Security no.:		Home phone no.: (    )	
P.O. box:	City:	State:	ZIP Code:		
Occupation: Cell Phone: (    )	Employer: Ethnicity:	Employer phone no.: (    )			
Chose clinic because/Referred to clinic by (please check one box):			<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other	
Other family members seen here:					

DO YOU HAVE A PHARMACY YOU WOULD LIKE US TO SEND YOUR PRESCRIPTIONS TO?

Local:

Mail Order:

## INSURANCE INFORMATION

**(Please give your insurance card to the receptionist.)**

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: (    )
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Occupation:	Employer:	Employer address:	Employer phone no.: (    )
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please indicate primary insurance		<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Cigna
		<input type="checkbox"/> Aetna	<input type="checkbox"/> United Healthcare
		<input type="checkbox"/> MedCost	
<input type="checkbox"/> Medicare	<input type="checkbox"/> Partners Medicare	<input type="checkbox"/> Medicare Complete UHC	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Other			
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:
			Policy no.:
			Co-payment: \$
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
	<input type="checkbox"/> Other		

## IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: (    )	Work phone no.: (    )
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

\_\_\_\_\_  
*Patient/Guardian signature*

\_\_\_\_\_  
*Date*

# Kernersville Primary Care REGISTRATION FORM

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## ALL PATIENTS PLEASE COMPLETE THIS SECTION

Kernersville Primary Care has my permission to speak with the following people regarding , medical treatment, test results and billing issues:

Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:

I give permission to Kernersville Primary Care to leave message at:     Home                       Work

*Patient/Guardian signature:*

*Date*

## \*PLEASE COMPLETE THE REST OF THE APPLICATION ONLY IF THE PATIENT IS A MINOR/CHILD\*

Patient's legal guardian last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:	Social Security no.:		Home phone no.:		
P.O. box:	City:	State:	ZIP Code:		

## OTHER PARENT OR PERSON WHO HAS YOUR PERMISSION TO SEEK TREATMENT FOR THIS MINOR

Patient's legal guardian last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:	Social Security no.:		Home phone no.:		
P.O. box:	City:	State:	ZIP Code:		

## PLEASE SIGN THE FOLLOWING STATEMENT

I agree to accept financial responsibility or  I have provided the attached legal document or notarized statement assigning financial responsibility for services provided by Kernersville Primary Care.

To: (Child's Name)

Your Signature:

Date:

## \*\*\* OPTIONAL " PERMISSION TO TREAT" AUTHORIZATION FOR TEENAGE CHILDREN

I give Kernersville Primary Care permission to treat my teenage child if he/she seeks medical care or advice without my knowledge

Signature:	Relationship to patient:	Date:
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