APPLEGATE VALLEY FAMILY MEDICINE

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security No.:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Address (for responsible party):	Phone No.: ( )

P.O. box:	City:	State:	ZIP Code:

Pharmacy:

(The follow questions are voluntary and used solely for Meaningful Use purposes).

Race: ❑ Declined ❑ American Indian/ Alaska Native ❑ Asian ❑ Black/ African American ❑ Nat Hawaiian/ Pacific Islander ❑ Other ❑ White

Ethnicity: ❑ Declined ❑ Hispanic or Latino ❑ Not Hispanic or Latino

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No

Name of **primary** insurance:	Policy No.:	Group No.:
Name of **secondary** insurance (if applicable):	Policy No.:	Group No.:

IN CASE OF EMERGENCY

Name of relative, guardian or POA:	Relationship to patient:	Phone No.: ( )	
Street Address:	City:	State:	Zip:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to AVFM. I understand that I am financially responsible for any balance. I also authorize Applegate Valley Family Medicine, billing company and insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*