

# Welcome to Family Healthcare Partners

## PATIENT REGISTRATION FORM - PATIENT INFORMATION

HAVE YOU EVER BEEN SEEN BY ANY OF OUR HEALTHCARE PROVIDERS? YES NO

<b>Last Name</b>		<b>First</b>			<b>M.I.</b>
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>	
<b>Home Phone</b>		<b>Work Phone</b>		<b>SS #</b>	
<b>Birthdate</b>	<b>Age</b>	<b>Sex (circle one)</b> M F	<b>Marital Status</b> S M W D Sep	<b>Spouse's Name</b>	
<i>Patient Employment Status</i> Full Time Part Time Unemployed Retired Disability		<b>Patient Employer</b>			<b>Employer Phone</b>
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>	

### RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

<b>Last Name</b>		<b>First</b>			<b>M.I.</b>
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>	
<b>Home Phone</b>		<b>Work Phone</b>		<b>SS #</b>	
<b>Employer</b>	<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>

### INSURANCE INFORMATION

<b>Primary Insurance Company</b>			<b>Phone</b>		
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>	
<b>Insured's Name</b>		<b>ID #</b>	<b>Group #</b>	<b>Birthdate</b>	
<b>Insured's Employer</b>			<b>Employer's Address</b>		

<b>Secondary Insurance Company</b>			<b>Phone</b>		
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>	
<b>Insured's Name</b>		<b>ID #</b>	<b>Group #</b>		
<b>Insured's Employer</b>			<b>Employer's Address</b>		

**Drug Allergies (Please List)**

# Welcome to Family Healthcare Partners

**Emergency Contact** – Other than a person residing in the same Household :

Name : \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship : \_\_\_\_\_

**Person Family Healthcare Partners, LLC is permitted to Divulge Medical Information to :**

Name : \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship : \_\_\_\_\_

## *Acknowledgement of Receipt of Privacy Notice*

I have been presented with a copy of Family Healthcare Partners, LLC **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

\_\_\_\_\_  
\_\_\_\_\_

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.  
Regulations pertaining to medical assignment of benefits apply.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If not signed by patient, please indicate relationship to patient (e.g., spouse)

**Relationship:** \_\_\_\_\_ **Witnesses by:** \_\_\_\_\_

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### **Internal Use Only:**

If patient or patient's representative refuses to sign acknowledgement of receipt of notice;  
Please document the date and time the notice was presented to patient and sign below.

**By:** NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_

DATE : \_\_\_\_\_ TIME: \_\_\_\_\_