



Family Practice/Internal Medicine

REGISTRATION FORM

NAME: _____ DATE OF BIRTH: _____
LAST FIRST MI

ADDRESS: _____
STREET/PO BOX CITY STATE ZIP CODE

GENDER: ___ Male ___ Female MARITAL STATUS: ___ Single ___ Married ___ Divorced/Separated

SOCIAL SECURITY NUMBER: _____ HOME PHONE #: _____

CELL NUMBER: _____ PAGER: _____

EMPLOYER: _____

ADDRESS: _____

WORK PHONE NUMBER: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

ADDRESS: _____ RELATIONSHIP: _____

PHONE #: _____ WORK PHONE #: _____ CELL #: _____

INSURANCE INFORMATION:

GUARANTOR: _____ RELATIONSHIP: _____

GUARANTOR'S S.S.NUMBER: _____

PRIMARY INSURANCE: _____

POLICY NUMBER: _____

POLICY CARRIER: _____

SECONDARY INSURANCE: _____

POLICY NUMBER: _____

POLICY CARRIER: _____

HOW DID YOU HEAR ABOUT US? ___ WEB SITE ___ MOVIE THEATRE
___ NEWSPAPER ___ WORD OF MOUTH ___ OTHER _____

IT IS MY UNDERSTANDING THAT F.F.THOMPSON FAMILY PRACTICE WILL BILL MY INSURANCE COMPANY ON MY BEHALF FOR COVERAGE OF MY VISIT. I ALSO UNDERSTAND THAT IF MY POLICY HAS A DEDUCTIBLE, COPAYMENT, OR DOES NOT COVER CERTAIN PROCEDURES, I AM RESPONSIBLE FOR THAT BILL. IN THE EVENT THAT MY CHECK IS RETURNED DUE TO INSUFFICIENT FUNDS, I REALIZE THAT I AM RESPONSIBLE FOR THE BANK SURCHARGE OF \$10.00 OR GREATER IF DICTATED BY THE BANK.

SIGNATURE: _____ DATE: _____