Family Care Associates

Patient Registration Form

New Patient: _____ Address Change: _____ Insurance Coverage: _____

Name Change: _____ Old Name: ________________________________

PATIENT Please print all info & circle where appropriate	SUBSCRIBER Complete this box only if patient is NOT subscriber Write SAME if patient is the subscriber Please print all information entered and circle where appropriate.
LAST FIRST MI	LAST FIRST MI
STREET	STREET
CITY STATE ZIP	CITY
HOME PHONE # ____________________	DATE OF BIRTH: ____________________
WORK PHONE # ____________________	SEX: Male Female
CELL PHONE # ____________________	Patient relation to subscriber: Spouse Child Other
DATE OF BIRTH: ____________________	**INSURANCE INFORMATION** Please print all information clearly and completely. Precise information will get your claim paid promptly.
SOCIAL SECURITY # ____________________	Primary Insurance:
STATUS: Single Married Other	Ins. Carrier Name: ____________________
SEX: Male Female	Ins. ID Number: ____________________
Employed: Y N P/T F/T Employer Name: __________	Ins. Group Number: ____________________
Student: Y N P/T F/T School Name: __________	Secondary Insurance:
In case of emergency, please notify:	Ins. Carrier Name: ____________________
Name	Ins. ID Number: ____________________
Phone #:	Ins. Group Number: ____________________

MY INSURANCE CO-PAY AMOUNT IS: $ ________

I authorize the release of any medical or other information necessary to process this claim. I authorize insurance payments to be made directly to Dr. David Chodirker, Dr. Ronda Rocket, or Dr. Jonathan Snider. I am personally responsible for all deductibles and any other charges denied by my insurance carrier. I will provide a referral if necessary or be liable for the full charge. Any Lab/Incidental charges for this and any future visits are my responsibility.

Patient Signature: ______________________________ **Date:** ____________________

Office Use Only: Insurance Card Copied: __________ Ins. Eligibility Validated: __________