FAMILY FIRST
WOMEN & CHILDREN'S HEALTHCARE
MEDICAL AESTHETICS

Patient Registration

Information about the PATIENT:			
Patient Name:		Date of Birth:	
Address:			
City/State/Zip:			
Mobile Phone:			
E-mail (Parent if patient a minor)			
Social Security #:		Home Phone:	
Preferred Pharmacy:		Work Phone:	
If the patient is a minor, complete the information below for each PARENT:			
Parent/Guardian:		Cell Phone:	
Address (if different):			
Parent/Guardian:		Cell Phone:	
Address (if different):			
Information about your PRIMARY insurance:			
Insurance Name:			
Policyholder Name:		Date of Birth:	
Employer:			
Social Security #:		Relationship:	
ID Number:		Group #:	

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OVER

If you have SECONDARY insurance, complete the information below:			
Insurance Name:			
Policyholder Name:		Date of Birth:	
Social Security #:		Relationship:	
ID Number:		Group #:	

E-Newsletter

❑ Check here to opt-in to receive our e-newsletter to the email address provided above. Family First Physicians sends monthly e-newsletters and periodic emails to our patients with health news and special offers from our practice.

Release of Information, Authorization for Assignment of Benefits and Financial Agreement

I authorization Family First Physicians to release to my insurance company (or its representatives) information including diagnosis and the records of any treatment or examination rendered to me that they may be required to process my claim for benefits.

I authorize and request that my insurance company (commercial or governmental) pay directly to Family First the amount due me in pending claims for medical treatments or services by reason of such treatments or services rendered to me. This assignment will remain in effect until revoked by me in writing.

It is understood that, whether I sign as patient or responsible party, I am directly responsible for services rendered which are not paid by my insurance. I certify that to the best of my knowledge, the information contained on this Patient Registration Form is correct and true. I will notify Family First in case of any changes in the information contained on this form.

Patient or Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Date: _____