Sylvania Family Physicians
Patient Registration

Patient Information

Name: ____ DOB: ______________________

Address: ________________________ City: ________________ State: ___________ Zip: ________

Home #: ___________________Day/Work #: _____________________Cell #: ___________________

SSN: __________________________ Sex: Male Female Marital Status: ______________________

Can we communicate with you via email? Email address: ____________________________________

How did you hear about our office? Friend/Family Advertisement Phone Book Insurance Co.

Employer: ____

Insurance Information

Primary Insurance: _________________________________ ID #: ___________________________

Policy Holder's Name: ___________________________________ DOB: _______________________

Relationship to Patient: ___________________________________ SSN: ______________________

Address: _____________________ City: __________________ State: _____________ Zip: _______

Employer: ____

Secondary Insurance: ______________________________ ID #: ____________________________

Policy Holder's Name: __________________________________ DOB: ________________________

Relationship to Patient: _________________________________ SSN: _________________________

Address: _____________________ City: __________________ State: _____________ Zip: _______

Employer: ____

Emergency Contact

Name: ____ Relationship: ____________________

Home #: __________________ Day/Work #: ___________________ Cell #:_____________________

ASSIGNMENT OF BENEFITS/AUTHORIZATION OF TREATMENT
I hereby authorize treatment and authorize the provider of medical services to release information for services to the insurance carrier or any agency providing services or benefits in order to review or process claims. I further authorize payment of benefits directly to the provider.

FINANCIAL RESPONSIBILITY
I understand that I am financially responsible for all charges not covered by the insurance company.

____
Signature of Patient or Patient Representative Date

For office use only:

Update by: ___________ Date: ___________ Scanned by: _____________ Date: _____________