

**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: _____

MANNER OF CONTACT

Patient Name: _____ DOB: _____

I wish to be contacted in the following manner (check all that apply):

Oral communication:

- Home telephone # _____ Work telephone # _____
- O.K. to leave message with detailed information. O.K. to leave message with detailed information.
- Leave message with call-back number only. Leave message with call-back number only.
- O.K. to communicate using email _____
- Other: _____

Written communication:

- O.K. to mail to my home address. O.K. to fax to this # _____
- O.K. to mail to work/office address. Other: _____

I permit the Agency to discuss my PHI (personal health information) with, and to disclose my PHI to, the following individuals.

- Spouse _____
- Adult Children _____
- My parent(s) _____
- Personal representative _____

If checked, the following additional instructions apply:

Patient signature

Date

If signed by patient's authorized representative, describe the representative's authority:

- Patient is a minor; I am the patient's parent and natural guardian.
- Patient is a minor, I am the patient's guardian, appointed by the _____ County Juvenile Court.
- Patient is a ward; I am the patient's guardian, appointed by the _____ County Juvenile Court.
- The patient is deceased. I am the patient's surviving spouse.
- The patient is deceased. I am the executor or administrator of the patient's estate, appointed by the _____ County Probate Court.
- I am the patient's attorney in fact, as designated in the patient's Durable Power of Attorney for Health Care.
- Other (describe): _____

