Print Form

Horizon Family Medicine, PA
Five Locations With One Purpose . . . Your Health
www.horizonfamilymed.com

PATIENT REGISTRATION FORM

PATIENT INFORMATION – *Please Print*

Legal Name (First, Middle, Last): _____ Suffix: _____

SSN: _____ Date of Birth: _____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Home Address: _____ City, ST, Zip: _____

Mailing Address: _____ City, ST, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ (*This is part of your protected health record and will not be sold or spammed*)

Employer: _____ Occupation: _____

Gender: ❑ Male ❑ Female Race: ❑ White/Caucasian ❑ Black/African American ❑ Other First Language: ❑ English ❑ Spanish ❑ Other Ethnicity: ❑ Hispanic ❑ Non-Hispanic

EMERGENCY CONTACT – *Who may we contact in case of an emergency?*

Name: _____ Relationship to patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

RESPONSIBLE PARTY – *Custodial parent, if patient is under 18 years old*

Legal Name (First, MI, Last): _____ ID #, DL # or SS #: _____

Relationship to Patient: _____ Date of Birth: _____ Employer: _____

INSURANCE – *You may leave blank if we scanned your card(s)*

	Primary Insurance	Secondary Insurance
Company		
Policy #		
Group #		
Policy Holder's Name		
Relationship to Patient		

PRIVACY INFORMATION (HIPAA)

I authorize Horizon Family Medicine to contact me and/or to leave telephone messages in the following ways:

❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ Email

I authorize Horizon Family Medicine to release my medical information to the named persons listed below:

❑ Spouse/Parents/Children (Print Name):_____

❑ Other (Print Names and Relationship to the Patient):_____

READ & SIGN BELOW

I certify that the information provided is correct and complete to the best of my knowledge.

_____ _____

Signature of Patient (or Legal Guardian) **Date**