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 ❑ Other ❑ Black/African American First Language: ❑ English ❑ Other ❑ Spanish 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 –

	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**

HFM-PR 042513