Patient Registration – Tolt River Family Medicine

Section 1: Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Gender: _____ Other names that records may be kept under: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Please list phone numbers where we may leave confidential voicemail messages:

Best number (_____)_____ ☐ Home ☐ Work ☐ Cell

Alternative number (_____)_____ ☐ Home ☐ Work ☐ Cell

E-mail : _____ ☐ I consent to receiving invoices and appointment reminders via email

Parents' Names (minors only): _____ _____

Emergency Contact: _____ Contact's Phone #: (_____)_____

Relationship to Emergency Contact: _____ Do you have special needs? _____

How did you hear about our clinic?_____

Section 2: Insurance Information

Insurance Company:_____ Member ID number_____ Group ID_____

Policy Holder Name:_____ **Policy Holder Date of Birth**:_____

Policy Holder Address (if different):_____City/State/Zip_____

Policy Holder Phone Number_____ Policy Holder Employer_____

Patient relationship to policy holder: ☐self ☐spouse ☐child ☐other

Permission to bill your insurance company and have payments sent to Tolt River Family Medicine

I certify that I, and/or my dependents(s), have insurance coverage with _____ and I assign directly to Tolt River Family Medicine the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on insurance claim submissions. Tolt River Family Medicine may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient or Responsible Party_____ Date:_____

Section 3: Receipt of Policies

I hereby acknowledge that I have reviewed the Tolt River Family Medicine:

- **Informed Consent Document**
- **Notice of Privacy Practices**
- **Financial Policy**

I agree to the terms contained within those documents.

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Relationship to Patient Date