Patient Registration – Tolt River Family Medicine

Section 1: Patient Information

First Name: ______________________ Middle Name: _____________________ Last Name: ______________________________

Date of Birth: ____________ Sex: ______ Other names that records may be kept under: __________________________________

Address: ____ City: ______________________ State: ______ Zip Code: __________

Please list phone numbers where we may leave voicemail messages:

Best number (______)________________ ☐ Home ☐ Work ☐ Cell

Alternative number (______)__________________ ☐ Home ☐ Work ☐ Cell

Email Contact: ____

Employer/School: ____

Mother's Name (minors only): ___________________________ Father's Name (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

Assignment and Release

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

Privacy Terms: Tolt River Family Medicine (TRFM) keeps a record of the healthcare services provided to you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the records. TRFM will not disclose your medical information to others unless you direct them to do so or applicable laws authorize or compel them to do so. TRFM is required to provide you with a copy of the Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information or our financial policy, contact the office at (425) 333-4600.

I hereby acknowledge that I have received the Notice of Privacy Practices and the 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