Patient Registration Form

Family Practice

Patient Information

Patient Information:

Last Name:	**First Name:**	**M.I.:**
Mailing Address:		**Apt#**
City/State/Zip:		
Home Phone:	**Cell Phone:**	**Work Phone:**
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text		**If Voice, Please Select Preferred Number:** ☐ Home ☐ Cell ☐ Work
Prior Physician or Medical Group:	**Date of Birth:**	**Sex:** ☐ Male ☐ Female ☐ Transgender
Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other		
Employer Name:	**Emergency Contact Name:**	
Emergency Contact Phone#:		**Relationship to Patient:**

Additional Information and Responsible Party

Responsible Party• If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:

Last Name:	**First Name:**	
Date of Birth:	**Email address:**	**Phone:**
Address of Person Responsible:		
City/State/Zip:	**Relationship to Patient:**	

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Race (please select one):

☐ White ☐ American Indian or Alaska Native ☐ Asian
☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Other ☐ Decline

Ethnicity (please select one):

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline

Preferred Language (please select one): ☐ English ☐ Spanish ☐ Sign Language ☐ Other (please specify):

Preferred Pharmacy Name & Location:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	**Ins. Co. Name**
ID Number:	**ID Number:**
Policy Holder's Name:	**Policy Holder's Name:**
Policy Holder's Date of Birth:	**Policy Holder'sDate of Birth:**
Patient Relationship to Policy Holder:	**Patient Relationship to Policy Holder:**

I certify that I am eligible for the insurance indicated on this form, and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Melissa Hurd Medical Corporation (MHMC) all money to which I am entitled for medical expenses related to the services performed by MHMC but not to exceed my indebtedness to MHMC. I authorize MHMC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from MHMC by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. Comments submitted on surveys may be anonymously shared on the MHMC Public Website.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to MHMC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Melissa Hurd Medical Corporation's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: X _____ **Date:** _____

Printed Name of Responsible Party: X _____ **Date:** _____