



Family Health Care
Baldwin • Cadillac • Grant • McBain • White Cloud
 www.familyhealthcare.org



PATIENT REGISTRATION

Chart# _____ Account # _____

Patient Name _____
 Last Maiden (if any) First Middle Initial

Address #1 _____ Address #2 _____

City _____ State _____ Zip _____

Date of Birth _____ Sex M F Social Security # _____

Home Phone # _____ Work Phone # _____

Emergency Contact: _____ Phone #: _____

If Patient is a Minor (under the age of 18), please complete the following:

Guarantor (Person Financially Responsible for Minor Patient)

Name _____ Relationship _____
 Last First to Patient

Address #1 _____ Address #2 _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Date of Birth _____ Social Security # _____

Parents of Minor Patient

Mother _____ SSN _____

Father _____ SSN _____

Note: If parents of minor patient are divorced or separated, please complete the following:

Person with **Legal** Custody of Minor Patient ___Mother___Father___Both___Other (Name)_____
 (Legal Custody gives a parent the right to seek medical care on behalf of the minor patient. Most parents share Joint Legal Custody.)

Please list any other person who may bring the minor patient to Family Health Care/Great Lakes Family Care:

Step Parent _____ Step Parent _____

Grand Parent _____ Grand Parent _____

Other _____ Relationship to Patient _____

Please note that Legal Custodian must file a Limited Power of Attorney form for any other person who will be bringing minor patient into Family Health Care/Great Lakes Family Care. Please request a form from the Registration staff.

Insurance Information

(Please list all applicable coverage)

Insurance #1 _____ Contract # _____ Group # _____

Subscriber's Name _____ Subscriber's Social Security # _____

Subscriber's Date of Birth _____ Employer's Name _____

Billing Address (This is not needed for Medicare, Blue Cross and Medicaid – Complete for Commercial Insurance Only)

Effective Date of Coverage _____

Insurance #2 _____ Contract # _____ Group # _____

Subscriber's Name _____ Subscriber's Social Security # _____

Subscriber's Date of Birth _____ Employer's Name _____

Billing Address (This is not needed for Medicare, Blue Cross and Medicaid – Complete for Commercial Insurance Only)

Effective Date of Coverage _____

Auto Insurance (If visit is related to Auto Accident) _____

Insurance Office Name & Address _____

Contact Person or Adjustor Name _____ Claim # _____

Family Health Care/Great Lakes Family Care – Financial Policy Summary

We will file your claim to the Insurance(s) indicated. If we are unable to successfully collect reimbursement from your carrier, FHC/GLFC will seek payment from the Guarantor indicated on the reverse side of this form.

FHC/GLFC supports the policy of collecting deductibles, co-pays and any other related out of pocket expenses at time of service. Patients without insurance may be eligible for reduced fee services. If you are unable to pay at the time of service, you may meet with a Financial Counselor to establish payment arrangements.

I have reviewed the above statement and agree that I am responsible for any outstanding charges for all professional services provided.

Signature of Patient (or Guardian)

Date of Signature

I authorize the release of any medical/dental information necessary to process my claims.

Signature of Patient (or Guardian)

Date of Signature

I authorize my Insurance Carrier to pay medical/dental benefits directly to FHC/GLFC on my behalf.

Signature of Patient (or Guardian)

Date of Signature