



**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

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Email Address: \_\_\_\_\_

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 \_\_\_\_\_

**Parents of Minor Patient**

Mother \_\_\_\_\_ DOB \_\_\_\_\_

Father \_\_\_\_\_ DOB \_\_\_\_\_

**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.**

Please complete side 2

**Insurance Information**

*(Please list all applicable coverage)*

Insurance #1 \_\_\_\_\_ Contract # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

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 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