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

AAAHC

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