Family Health Care

PATIENT REGISTRATION

Patient Name: ____
Prefix (Mr., Mrs.) Last Maiden (if any) First Middle Initial Suffix (Jr., Sr.) Nickname

Social Security Number (last 4 digits only): ____________ Date of Birth: ____________ Birth Sex: ☐ M ☐ F

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

Home Phone #: ____________ Cell Phone #: ____________

Patient's Employer: ______________________ Phone #: ____________

Emergency Contact: ______________________ Phone #: ____________

Appointment Reminder Contact Method : ☐ Phone ☐ Text ☐ Email

How did you hear about FHC? (Please circle one)

Billboard
Brochure
Event

Facebook / Instragram / Social Media
Family / Friends
Flier / Poster

Google / Yahoo / Search Engine
Insurance Carrier
Newspaper / Magazine

Phonebook
Post Card
Website

Other: ____________

If patient is a minor (under the age of 18) please complete the following:

Guarantor (Person financially responsible for minor patient)

Name: ______________________________________ Relationship to Patient: ____________
Last First

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

Home Phone #: ____________ Work Phone #: ____________ Cell Phone #: ____________

Parents of minor patient

Mother: ______________________________ Date of Birth: ____________

Father: ______________________________ Date of Birth: ____________

Insurance Information (*Please list all applicable coverage*)

Insurance #1: ____________________ Contract #: ____________ Group #: ____________

Subscriber's Name: ______________________ Date of Birth: ____________

Employer's Name: ______________________________

Billing Address - *Complete for Commercial Insurance only*: ______________________________

____

Effective Date of Coverage: ____________

Please complete side 2

Form #2008
07-10-19

Insurance #2: ______________________ Contract #: ______________ Group #: ______________

Subscriber's Name: ______________________ Date of Birth: ______________

Employer's Name: ______________________

Billing Address - *Complete for Commercial Insurance only*:

______________________ Effective Date of Coverage: ______________

☐ Please enroll me in the Patient Portal (*Please provide Email Address, Date of Birth and City of Birth*)

Email Address: ______________________ Date of Birth: __________ City of Birth: __________

List dependents you want added to your Portal:

Dependent's Name	Date of Birth	Dependent's Name	Date of Birth
Dependent's Name	Date of Birth	Dependent's Name	Date of Birth

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By signing below, I authorize Baldwin Family Health Care (BFHC) and its affiliates to contact me by automated SMS text message for appointment reminders, marketing, and other information pertaining to my care. I understand that message / data rates may apply to messages sent by BFHC or its affiliates under my cell phone plan. I know that I am under no obligation to authorize BFHC or its affiliates to send me text messages. I may opt out of receiving these communications at any time by calling the office or by responding STOP to any message I receive from BFHC.

Please allow 2 - 3 business days for processing. I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date / time of appointments, name of physician, and physician phone number, or other pertinent information. By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from BFHC and its affiliates to the phone number that I have provided.

Signature required if requesting text message reminder

______________________ ______________

Signature of Patient (or Guardian) Date of Signature

Family Health 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 will seek payment from the Guarantor indicated on the reverse side of this form.

FHC 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.

This health center receives HHS funding and has Federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals.

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

______________________ ______________

Signature of Patient (or Guardian) Date of Signature

I authorize the release of any medical / dental / vision information neccessary to process any claims.

______________________ ______________

Signature of Patient (or Guardian) Date of Signature

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

______________________ ______________

Signature of Patient (or Guardian) Date of Signature