Family Health Care

PATIENT REGISTRATION

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

Social Security Number: _____ **Date of Birth:** _____ **Birth Sex:** ☐ M ☐ F

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Cell Phone #: _____ **Home Phone #:** _____ **Email Address:** _____

Patient's Employer: _____ **Phone #:** _____

Emergency Contact: _____ **Phone #:** _____

Appointment Reminder Contact Method: ☐ Phone ☐ Text ☐ Email

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

Billboard	Facebook / Instagram / Social Media	Google / Yahoo / Search Engine	Phonebook	Other: _____
Brochure	Family / Friends	Insurance Carrier	Post Card	
Event	Flier / Poster	Newspaper / Magazine	Website	

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: _____ Subscriber's Date of Birth: _____

Employer's Name: _____

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

_____

Effective Date of Coverage: _____

Please complete side 2

Insurance #2:_____ **Contract #:**_____ **Group #:** _____

Subscriber's Name:_____ **Subscriber's Date of Birth:** _____

Employer's Name:_____

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

_____

Effective Date of Coverage: _____

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 outstanding charges for all professional services provided.

_____ _____

Signature of Patient (or Guardian) **Date of Signature**

I authorize the release of any medical / dental / vision information necessary 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**