

**North Macon Family Health Care Associates, LLC**  
REGISTRATION FORM

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

SS #: \_\_\_\_\_

Patient Employed By: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_ M / F

Work Addr: \_\_\_\_\_

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

Primary Insurance: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Widowed \_\_\_\_ Divorced

Referring Physician: \_\_\_\_\_

**SPOUSE INFORMATION**

Name: \_\_\_\_\_

Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

SS # : \_\_\_\_\_

Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Work Addr: \_\_\_\_\_

**MUST COMPLETE IF UNDER 18**

**Father**

**Mother**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

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

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

SS # : \_\_\_\_\_

SS # : \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

**AUTHORIZATIONS**

\*\*\*\*\*PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST\*\*\*\*\*

- I hereby authorize and request the medical treatment necessary for the care of the above named patient.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow the fax transmittal of my medical records, if necessary.
- I acknowledge full financial responsibility for services rendered by **North Macon Family Health Care Associates, LLC**. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I understand that I am responsible for any un-met deductibles and co-insurance fees.
- I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my insurance authorizes and to inform the staff of **North Macon Family Health Care Associates, LLC** as to which laboratory my insurance covers.
- I further authorize and request that insurance payments be made directly to **North Macon Family Health Care Associates, LLC**, for services rendered. **I have read and fully understand the above consent for treatment, release of medical information, financial responsibility and insurance authorization.**

\_\_\_\_\_  
Patient / Parent or Guardian ( Please Print )

\_\_\_\_\_  
Patient / Parent or Guardian Signature

\_\_\_\_\_  
Date