

Mitchell Family Medicine

Patient Registration Form

Patient Name _____

Sex M F Age _____ Date of Birth ____/____/____ Social Security No _____

Marital Status S M W D Sep Spouse (or parent if minor) _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell _____

Employer _____ Occupation _____

Employer's Address _____

City _____ State _____ Zip Code _____

Emergency Contact _____ Relationship _____

Address _____

City _____ State _____ Zip _____ Phone _____

Primary Insurance Company _____

Identification No _____ Group No. _____ Effective Date ____/____/____

Policy Holder _____ Social Security No _____ Date of Birth ____/____/____

Policy Holder Address _____

City _____ State _____ Zip Code _____

Relationship to Patient _____ Employer _____

Assignment of Benefits

I authorize payment of medical benefits to the provider for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature below will bind me as though I personally signed the claim. **I understand that I am responsible for all charges not covered by my insurance.** If this account should be referred to a collection agency, I will be responsible for all collection and legal fees. I authorize the release of any medical or other information necessary to process my medical claims. I also authorize payment of government benefits either to myself or to the party who accepts assignment. I have read and understand the office policy and procedures.

Signature of the Patient or the Patient's Legal Representative

Date

Print Name

If not the Patient; please state your relationship to the Patient.