Fogarty Surgical Services & Family Care Clinic

REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Sex:	Birth date:	Age:

Street Address:	P.O. Box:	City:	State:	Zip:

Marital Status:	Social Securty no:	Home Phone:	Cell Phone:	Work Phone:

Employer:	Occupation:	Can we call you at work?/ hours?

Spouse or Parent's name:	Pharmacy:	Who referred you?

RESPONSIBLE PARTY INFORMATION

Person responsible for bill:	Birth date:	SSN:	Relationship:

Address (if different:)	Home Phone:

Employer:	Employer's Address:	Work phone:

INSURANCE INFORMATION

Primary Insurance:	Claim Address:

Subscriber's Name:	Birth Date:	Social Security No.:	Relationship to patient:

Insurance ID:	Group no.:	Co-Pay:	Comments:

Secondary Insurance:	Claim Address:

Subscriber's Name:	Birth Date:	Social Security No.:	Relationship:

Insurance ID:	Group no.:	Co-Pay:	Comments:

Were you injured on the job?	Have you informed your Employer?	Date of Original Injury:	Dates off of work:

Worker's Compensation Carrier Name:	Address:

Claim No.:	Case Manager:	Phone no.:

CONTACT IN CASE OF EMERGENCY

Name of friend/relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize Fogarty Surgical Services & Family Care Clinic or my insurance company to release any information required to process my claims. Patient understands that they are responsible for any portion(s) not paid by insurance within a reasonable period of time. In the event of default, under the terms of this agreement, this office may at its discretion place the account for collection with any collection agency or attorney. Patient agrees that in addition to outstanding bills, they will be responsible for all costs of collections including but not limited to collection agency fees, attorney fees and court costs.
(PLEASE READ & SIGN FINANCIAL POLICY ON BACK SIDE OF THIS FORM.)

Patient/Guardian signature	*Date*