**REGISTRATION FORM**

(Please Print)

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| **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | |
| Patient’s Last Name: First: Middle: | | | | | | | | | | | | | Mr. Miss  Mrs. Ms. | | | | |
| Marital Status (Circle One): Single / Mar / Div / Sep / Wid | | | Email: | | | | | | | Birth Date:  / / | | | Age: | | | Sex:  M F Other | |
| Race (Circle One):  Caucasian/ African American/Asian/Other | | | | Ethnicity (Circle One):  Hispanic or Latino/ Not Hispanic or Latino/ Other/ Do Not Wish to  Disclose | | | | | | | | | Preferred Language: | | | | |
| Street Address: | | | | | | | | | | Social Security Number: | | | | | Home Phone: Preferred | | |
| City: | | | | | | | State: | | | Zip Code: | | | | | Cell Phone: Preferred | | |
| Occupation: | | | | | | | Employer: | | | | | | | | Employer Phone: Preferred | | |
| **Other Family Members seen here:** | | | | | | | | | | | | | | | | | |
| Preferred Pharmacy: | | | | | Location: | | | | | | Phone Number: | | | | | | |
| We make every effort to reach our patients in regards to their medical information. Gainesville Family Practice would like to insure that your medical information is properly protected as required by HIPAA guidelines. In the event that you are not available, please list names and phone numbers for those individuals with whom we may discuss your medical information. We will not leave messages containing sensitive health related information.   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | | | | | | | | | |
| Person Responsible for Bill: | Birth Date:  / / | | | | | | Address (if different than above): | | | | | | | | Home Phone: | | |
| Is this person a patient here? Yes No | | | | | | | | | | | | | | | | | |
| Occupation: | | Employer: | | | | | | Employer Address: | | | | | | | Employer Phone: | | |
| **Name of Primary Insurance:** | | | | | | | | | | | | | | | | | |
| Subscriber’s name: | Subscriber’s SSN: | | | | | Birth Date:  / / | | | Member ID/ Policy #: | | | Group #: | | | | | Co-pay:  $ |
| Patient Relationship to Subscriber: Self Spouse Child Other | | | | | | | | | | | | | | | | | |
| **Name of Secondary Insurance** (If applicable): | | | | | | Subscriber’s name: | | | | Member/ Policy #: | | | | Group #: | | | |
| Patient Relationship to Subscriber: Self Spouse Child Other | | | | | | | | | | | | | | | | | |
| **IN CASE OF EMERGENCY** | | | | | | | | | | | | | | | | | |
| Name of local friend or relative: | | | | | | Relationship to patient : | | | | Home Phone: | | | | Other Phone: | | | |
| I voluntarily consent to any and all healthcare treatment and diagnostic procedures provided by Gainesville Family Practice, PC and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other healthcare professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations of Gainesville Family Practice, PC.  I consent to the use and disclosure of my protected health information for the purposes of obtaining payment for services rendered, treatment, and healthcare operations consistent with the Notices of Privacy Practices. I acknowledge receipt of Notice of Privacy Practices. I authorize payment of medical insurance benefits to be made directly to Gainesville Family Practice, PC for services rendered.  I give permission to obtain my medication/ prescription history when using an electronic system to process prescriptions for my medical treatment.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Patient/ Guardian Signature Date* | | | | | | | | | | | | | | | | | |