

PLEASE READ THOROUGHLY AND SIGN ALL HIGHLIGHTED AREAS

America's Family Doctors PLLC (AFD) Registration Form

Patient Information:

First: _____ Middle: _____ Last: _____ Gender: M F

Date of Birth: ____/____/____ Marital Status: D M S W SS#: ____/____/____

Address: _____ Apt# _____ City & State: _____

Zip: _____ Phone:(Home) _____ (Cell) _____ (Work) _____

Race: _____ Language: _____ Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance
Subscriber Name: _____
Birth Date: ____/____/____ SS #: ____/____/____
Relationship: _____
Employer Name: _____
Insurance Policy ID #: _____

Secondary Insurance
Subscriber Name: _____
Birth Date: ____/____/____ SS #: ____/____/____
Relationship: _____
Employer Name: _____
Insurance Policy ID #: _____

Patient Employer: _____
Address: _____
City/State: _____ Zip: _____
Phone: _____

PLEASE READ AND FILL OUT THIS SECTION	
<u>Please check how you wish to be contacted for the following. Make sure your information is filled out completely at the top of the page. Please remember that some labs cannot be given except in person, i.e. STD or drug test results.</u>	
<u>Appointment Reminders:</u>	<u>Lab/Test Results:</u>
___ Email	___ Email
___ Mail	___ Mail
___ Phone Call	___ Phone Call
___ Text Message	___ Text Message

Financially Responsible Person (if different from patient)
First: _____ Last: _____
Date of Birth: ____/____/____ Gender: M F
SS# ____/____/____ Relationship: _____
Address: _____
City/State: _____ Zip: _____
Employer: _____
Address: _____
Phone: _____

<u>Consent to Treat and Release of Medical Records:</u>
I authorize AFD's medical providers to provide treatment that they deem advisable for my dependents or myself. I understand these services are voluntary and I have a right to refuse any service. In the event of a life-threatening emergency, I consent for the providers to administer emergency treatment. I authorize AFD to obtain any previous medical records, for myself or my dependents, including lab and X-Ray results, and narcotic database results, if the provider deems it necessary.

Pharmacy You Prefer To Use _____
Address if known: _____
City/State: _____ Zip: _____
Phone: _____

If you are SELF PAY and accrue additional charges while in office, you must pay all charges before leaving.

Please note - WE DO NOT PRESCRIBE ANY NARCOTIC OR ADDICTIVE MEDICATIONS

Do you have a Living Will or Advance Directive? _____ Would you like us to give you one? _____

Signature: _____ Date: _____

By signing this form, I acknowledge that I have been offered a copy of AFD's Privacy Policy (HIPAA).

Copy of Insurance Card and ID is required for everyone.