NORTHLAND FAMILY CARE, P.C.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last, First, Middle Initial)	Date of Birth	Social Security #
Address	Sex	Marital Status
City, State, Zip	Home Phone	Cell Phone

Primary Employer	Work Phone	Email

Employer's Address	City, State, Zip
Primary Physician / Referred By	Communication Preference: Please check at least one and provide information ______Home Phone ________________________________ ______Cell Phone __________________________________ ______Email _____________________________________
Medical Information may be given to those checked: _____Mother ______Father _____Other/Relationship_______________________________________	
Emergency Contact: Name, Relationship	Emergency Contact Phone #

PATIENT DEMOGRAPHICS - Please Check Where Applicable

Student ________YES _________NO _________Full-time Status ___________Part-time Status

Retired ________YES __________NO

Veteran or Current Military Status: ________Yes ________NO

Race:
_________White __________Black or African American ________American Indian or Alaska Native __________Asian
_________Native Hawaiian or Other Pacific Islander ________Unknown ___________Decline

Ethnicity: ________Hispanic or Latino _________Non-Hispanic or Latino ________Unknown _________Decline

Preferred Language Spoken

Do you smoke or use Tobacco Products _______Yes ________No

Revised July 2012 - Thank you for your assistance with government regulations

PATIENT REGISTRATION FORM

PAGE 2

****PLEASE NOTE THAT ALL CO-PAYS ARE DUE AT TIME OF SERVICE, THANK YOU****

PRIMARY INSURANCE INFORMATION

Name of PRIMARY Insurance Company	Policy #/ ID #	
Name of Policy Holder	Group#	
Relationship of Policy Holder to Patient	Co-Pay Amount	
Address of Insurance Company	Insured Social Security #	Insured Date of Birth
City, State, Zip	Effective Date	Expiration Date

SECONDARY INSURANCE INFORMATION

Name of SECONDARY Insurance Company	Policy #/ ID #	
Name of Policy Holder	Group#	
Relationship of Policy Holder to Patient	Co-Pay Amount	
Address of Insurance Company	Insured Social Security #	Insured Date of Birth
City, State, Zip	Effective Date	Expiration Date

PLEASE ATTACH A COPY OF INSURANCE CARD- IF NO COPY IS AVAILABLE, THE ACCOUNT WILL BE CONSIDERED "SELF-PAY"

Medical Authorization: The undersigned permits the physicians and all other personnel caring for the patient to examine, recommend treatment, and explain any associated risk involved. The undersigned also understands that this care may include diagnostic testing, examinations, or surgical treatment and no guarantees have been made regarding the outcome of this care.

Financial Agreement: I, the undersigned agree to be responsible for the balance of my account. Although an insurance claim (if applicable) will be filed with my insurance company by Northland Family Care on my behalf, negotiating payments through my insurance company is ultimately my obligation. I understand that payment will be made at the time of services rendered unless financial arrangements have been made PRIOR to the services. A statement will be mailed to me showing the balance due from me and will be considered past due after 30 days. If I am unable to make payment in full, I understand that I should contact the business office immediately to set up a payment arrangement. I understand that if no payment has been received or financial arrangements made on my balance, my account may be sent to collections. If my account is referred for collections, I understand that I will be responsible for the balance as well as any fees associated with the collection process.

SIGNATURE DATE