

Welcome to Fairlawn Family Practice

REGISTRATION FORM - ALL SECTIONS MUST BE COMPLETED

Section I:	Patient Information	Date _____
Name: _____ I Prefer to be called: _____		
Address: _____ City: _____ State: _____ Zip _____		
Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____		
OK to leave message on recorder <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of Birth: _____ Social Security Number: _____		
Check Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
If Student, Name of School _____ City/State _____ <input type="checkbox"/> FT <input type="checkbox"/> PT		
Spouse or Parent's Name: _____ Employer _____ Work Phone _____		
How did you hear about us <input type="checkbox"/> Newspaper <input type="checkbox"/> Internet <input type="checkbox"/> Family/Friend <input type="checkbox"/> Other _____		
Person to contact in case of emergency _____ Phone _____		
Email Address _____		

Section II	Responsible Party
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name: _____ BirthDate _____	
Address: _____	
City: _____ State: _____ Zip: _____ Phone: (_____) _____	
Employer _____ Work Phone (_____) _____ SSN# _____	

Section III	Insurance Information
Name of Insured _____ DOB _____ Relationship to Patient _____	
SSN#: _____ Name of Employer: _____ Work Phone: (_____) _____	
Address of Employer: _____ City _____ State: _____ Zip _____	
Insurance Company _____ Grp # _____ ID# _____	
Ins Co Address: _____ Ins Co. Phone: _____	
----- DO YOU HAVE ANY ADDITIONAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>IF YES, COMPLETE THE FOLLOWING</u>	

Name of Insured _____ DOB _____ Relationship to Patient _____	
SSN#: _____ Name of Employer: _____ Work Phone: (_____) _____	
Address of Employer: _____ City _____ State: _____ Zip _____	
Insurance Company _____ Grp # _____ ID# _____	
Ins Co Address: _____ Ins Co. Phone: _____	
THE RECEPTIONIST WILL ASK FOR YOUR INSURANCE CARDS AND COPAYMENT AT EVERY VISIT.	

I hereby request and consent to treatment and services provided by the physicians of Fairlawn Family Practice, Inc and PPG and authorize all payments directly to Fairlawn Family Practice and or PPG for all medical services provided. I assume responsibility for any unpaid balance including non-covered services except limited by law. I authorize the release of any medical or other information necessary to process my medical claims with Fairlawn Family Practice and PPG. I understand and acknowledge that the medical records may contain information regarding psychiatric disorders, HIV, AIDS related conditions and alcohol/and or drug dependency/abuse. This authorization for release of information is valid unless revoked by written notice to Fairlawn Family Practice, Inc providing said notice is received prior to the release of information.

Patient/Legal Guardian Signature: _____ Date _____