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 ___Yes ___No
Date of Birth:_____"_____ Social Security Number:_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name:_____ Employer_____ Work Phone_____
How did you hear about us ___Newspaper ___Internet ___Family/Friend ___Other _____

Person to contact in case of emergency_____ Phone_____
Email Address_____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ 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 ADDIONAL INSURANCE? ☐Yes ☐No IFYES, COMPLETETHE FOLLOWING

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_____