FamilyCare Medical Group, P.C.
Patient Registration Form

Please Print ***Date___________***

Name:____________________________ Sex___F ____M SS#________________________
Address:__________________________City_____________________Zip__________________
Phone_________________ Cell Phone____________________ Age__________ DOB __________________
Marital Status: ***Never Married___*** ***Married___*** ***Divorced/Separated____*** ***Widow/Widower____***
Patients Employer____ Occupation_____________________
Employers Address____Work Phone____________________
Emergency Contact____ Phone ___________
Spouse/Significant Others Name____
Spouse/Significant Others DOB:______________ SS#__________________________
Spouse's/Significant Others Employer _____________________________ Occupation_______________
Employers Address ____Work Phone___________________
Pharmacy Name & Address__________________________________ Pharmacy Phone #_________________
Language Preference______________Race___________Ethnicity___________Email _____________

Ethnicity: Non-Hispanic/Spanish Origin ____ ***Spanish/Hispanic Origin_____***
Patient Declined/Unknown_____

IF PATIENT IS A MINOR, COMPLETE THIS SECTION

Father's Name____________________________Father's DOB:__________Father's SS#_______________
Fathers Employer _________________________________ Work Phone ________________
Mother's Name___________________________ Mother's DOB: _________ Mother's SS#:_____________
Mothers Employer _________________________________ Work Phone ________________

HIPAA DOCUMENTATION
(Please answer all questions below and then sign and date)

1 I acknowledge that I have been given the opportunity to read and/or receive a copy of FamilyCare Medical Group's Privacy Notice. Y N

2. Leave appointment message on:
   - Answering Machine (including autocall)? Y N
   - Office Voice Mail ? Y N
   - w/ Person Listed Below ? Y N
   - Cell Phone (including autocall)? Y N

   Leave other medical info on:
   - Answering Machine (including autocall)? Y N
   - Office Voice Mail ? Y N
   - w/ Person Listed Below? Y N
   - Cell Phone (including autocall)? Y N

3. Person(s) authorized to Discuss the Above & relationship

   _________________________________ _____________________________________

   _________________________________ _____________________________________

Signature_______________________________________ Date______________________

*** I consent to have the Practice use and disclose my protected health information for payment, treatment and health care operations purposes, and for such other purposes that are permitted under HIPAA or other federal or state law without my written authorization.

Signature_______________________________________ Date______________________

*** I authorize the payment of medical benefits to above stated physician or supplier for services rendered.

Signature_______________________________________ Date______________________

12/03, 1/05, 5/05, 2/10, 1/11