Providence
FAMILY MEDICAL CLINIC

REGISTRATION FORM
Please fill out form completely

Today's Date	Email:

Patient Information

Last Name: First Name: MI

Date of Birth: Age: Gender: M F Ethnicity: Hispanic Non-Hispanic

Social Security Race:

Address:

City: State: Zip: Phone Number:

Insurance Information

Primary Ins: ID Number:

Address: City: State: Zip:

Phone Number:

Subscriber: Self Parent Spouse Other

Secondary Insurance: ID Number:

Address: City: State: Zip:

Phone Number:

Subscriber: Self Parent Spouse Other

RESPONSIBLE PARTY

Name: **DOB:** **Phone Number:**

Address: **City:** **State:** **Zip:**

Is todays visit related to a Work Injury, Car Accident, or Personal Injury YES NO

EMPLOYMENT

Employer Name: **Phone Number:**

Address: **City:** **State:** **ZIP:**

In case of Emergency

Name: Relationship: Phone Number:

HIPAA CONTACT

I give permission to the physician and staff of Providence Family Medical Clinic to share my confidential information with the person named below. I have received or have been provided the opportunity to receive a copy of Notice of Privacy that explains when, where, and why my confidential health information may be used or shared.

Name: **Relation:** **Phone No.**

The above mention information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Providence Family Medical Clinic. I understand that I will be financially responsible for any patient responsibility after the insurance has been billed.

Patient/Guardian Signature: **Date:**