Patient Registration Information
Please PRINT and complete all sections below

Patient's Personal Information

Gender: ☐Male ☐Female

Name: _____ _____ _____
LAST FIRST MIDDLE INITIAL

Date of Birth: _____ / ____ / _____ SS#: _____ Email: _____
MONTH DAY YEAR PREFERRED CONTACT METHOD ☐YES ☐NO

Address: _____ _____ _____ _____ _____
STREET APT# CITY STATE ZIP CODE

Home Phone: (____) _____ Cell Phone: (____) _____
PREFERRED CONTACT METHOD ☐YES ☐NO PREFERRED CONTACT METHOD ☐YES ☐NO

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow Spouses Name: _____

Primary Language: _____ Ethnicity: _____ Race: _____

Patient's / Guarantor's Employer: _____

Responsible Party / Guarantor Information

Name: _____ _____ _____
LAST FIRST MIDDLE INITIAL

Date of Birth: _____ / ____ / _____ SS#: _____ Email: _____
MONTH DAY YEAR

Address: _____ _____ _____ _____ _____
STREET APT# CITY STATE ZIP CODE

Home Phone: (____) _____ Cell Phone: (____) _____

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other_____

Patient's Insurance Information

Please present all insurance cards to receptionist

Primary Insurance Co. Name: _____ Policy #: _____

Name of Insured: _____ Group #: _____

Policyholder Date of Birth: _____ / ____ / _____ Policyholder SS#: _____
MONTH DAY YEAR

Insured Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other_____

Secondary Insurance Co. Name: _____ Policy #: _____

Name of Insured: _____ Group #: _____

Policyholder Date of Birth: _____ / ____ / _____ Policyholder SS#: _____
MONTH DAY YEAR

Insured Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other_____

Emergency Contact

☐ Yes ☐ No This person may be allowed to have appointment and medical record information

Name: _____ _____
LAST FIRST

Address: _____ _____ _____ _____ _____
STREET APT# CITY STATE ZIP CODE

Home Phone: (____) _____ Cell Phone: (____) _____

I hereby authorize Holy Family Medical Associates LLC to release any records/information needed to process insurance claims. I also authorize payment of benefits for services performed by physicians and/or physician extenders of Holy Family Medical Associates LLC. I also understand that regardless of insurance coverage, I am responsible for payment of any services provided by physicians and/or physician extenders of Holy Family Medical Associates LLC. A copy of this authorization is as valid as the original.

_____ _____
SIGNATURE OF PATIENT / LEGAL GUARDIAN DATE