HFMA Immediate Care Patient Registration
Please PRINT and complete all sections below!

Patient's Personal Information

Gender: ☐Male ☐Female

Name: ______________________ (LAST) ______________________ (FIRST) ________ (MIDDLE INITIAL)

Date of Birth: ______ / ____ / ______ (MONTH DAY YEAR) SS#: ______________________

Address: ______________________ (STREET) ______ (APT#) ______________ (CITY) ______ (STATE) ________ (ZIP CODE)

Home Phone: (____) ______________________ Cell Phone: (____) ______________________

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

Primary Language: ______________ Ethnicity: ______________ Race: ______________

Patient's Employer: ____

Responsible Party / Guarantor Information

I am my own Guarantor ☐ Yes

Name: ______________________ (LAST) ______________________ (FIRST) ________ (MIDDLE INITIAL)

Date of Birth: ______ / ____ / ______ (MONTH DAY YEAR) SS#: ______________________ Email: ______________________

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: ______ / ____ / ______ (MONTH DAY YEAR) Policyholder SS#: ______________________

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

Secondary Insurance Co. Name: ______________________ Policy #: ______________________

Name of Insured: ______________________ Group #: ______________________

Policyholder Date of Birth: ______ / ____ / ______ (MONTH DAY YEAR) Policyholder SS#: ______________________

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

Primary Care Contact

☐ Yes ☐ No I authorize the release of my health information to my primary care physician listed below

Name of your Primary Care Doctor: ____

I was referred here by my Primary Care Doctor: ☐ Yes ☐ No

Primary Doctor's Office 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