FALLBROOK FAMILY HEALTH CENTER, LLC

PATIENT REGISTRATION **TODAY'S DATE _____**

FIRST NAME _____ MIDDLE INITIAL_____ LAST NAME_____

PREFERRED NAME (if different than legal name) _____ DATE OF BIRTH _____ GENDER_____

SOCIAL SECURITY # _____ MARITAL STATUS Single Married Divorced Widowed Other_____

RACE: WHITE BLACK AM INDIAN/ESKIMO/ALEUT HISPANIC ASIAN/PACIFIC ISLANDER OTHER

ETHNICITY : HISPANIC/LATINO NOT HISPANIC/LATINO LANGUAGE: ENGLISH SPANISH OTHER

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ WORK PHONE # _____

EMPLOYER _____ OCCUPATION _____

EMERGENCY CONTACT _____ PHONE _____ HOW RELATED?_____

E-MAIL ADDRESS _____ HOW DID YOU HEAR ABOUT US?_____

IF MARRIED, SPOUSES'S NAME _____ SOCIAL SECURITY # _____

SPOUSE'S EMPLOYER _____ DATE OF BIRTH _____

PERSON RESPONSIBLE FOR BILL. IF SAME AS PATIENT, CHECK SAME HERE ☐

NAME _____ RELATION TO PATIENT _____

ADDRESS _____ DATE OF BIRTH _____

CITY _____ STATE _____ ZIP _____ SOCIAL SECURITY # _____

EMPLOYER _____ PHONE _____ HOME PHONE # _____

INSURANCE COVERAGE INFORMATION
PLEASE BE PREPARED TO PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST.

If you have already provided us with a copy of your insurance card, please check HERE ☐

Primary Insurance
NAME _____

ADDRESS _____

POLICY # _____ GROUP # _____

SUBSCRIBER _____

RELATION TO PATIENT _____

Secondary Insurance
NAME _____

ADDRESS _____

POLICY # _____ GROUP # _____

SUBSCRIBER _____

RELATION TO PATIENT _____

INSURANCE AND ASSIGNMENT OF BENEFITS AUTHORIZATION INFORMATION

I hereby authorize treatment of the above-named patient and agree to pay all charges for treatment regardless of insurance coverage or the pendency of insurance claims.

I authorize the release of all medical information to the above insurance carriers that is pertinent to my medical care and necessary to process my insurance claims. I will assign all medical and surgical benefits to Fallbrook Family Health Center, LLC. A photocopy of this form shall be as valid as the original. I understand that I can withdraw this medical benefit assignment at any time by notifying this office in writing.

I HAVE READ THIS INFORMATION THOROUGHLY AND UNDERSTAND IT.

PATIENT SIGNATURE _____ DATE _____
(Parent or legal guardian if minor)

SUBSCRIBER SIGNATURE _____ DATE _____
(Primary Insurance) (if different from patient)

SUBSCRIBER SIGNATURE _____ DATE _____
(Secondary Insurance) (if different from patient)