WILDWOOD FAMILY CLINIC, S.C.
PATIENT REGISTRATION FORM

PATIENT'S NAME: ____
Last Name First Name Middle Initial

Birthday ______/______/______ Age ________ Sex ______M______F SSN ______/______/ ______

Patient's Status _____Single _____Married _____Divorced _____Widowed Primary Physician ________________

Address ______________________________________ Home Phone ____________________

City, State, Zip ______________________________________ Work Phone ____________________

Employer Name ______________________________________ Cell Phone (if appropriate) ________________

Employer Address ____

Emergency Contact ______________________________________ Telephone ____________________

IF PATIENT IS MINOR, NAME OF PARENT OR GUARDIAN

Name ______________________________________ Relationship ____________________

Address ______________________________________ Home Phone ____________________

City, State, Zip ______________________________________ Work Phone ____________________

SSN _______/______/_______

Employer Name ______________________________ Address ______________________________

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance______________________________

Subscriber # ______________________________

Group # ______________________________

Effective Date ______________________________

Policy Holder Name ______________________________

Date of Birth ____________________ Sex (M) (F)

Relationship to Patient ______________________________

Policy Holder Employer______________________________

Employer Address______________________________

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SECONDARY INSURANCE

Insurance______________________________

Subscriber # ______________________________

Group # ______________________________

Effective Date ______________________________

Policy Holder Name______________________________

Date of Birth ____________________ Sex (M) (F)

Relationship to Patient______________________________

Policy Holder Employer______________________________

Employer Address______________________________

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AUTHORIZATION TO RELEASE AND ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. This includes balances beyond the "usual and customary" reimbursement by insurance companies. If the patient is uninsured, it is customary to pay for services when rendered unless other arrangements have been made in advance.

I request that payment of authorized Medicare/Other insurance company benefits be made on my behalf to the Wildwood Family Clinic, S.C. for any services furnished me by that party. I authorize any holder of medical information about me to release to the Social Security Administration and Centers for Medicaid & Medicare Services or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify my health care provider of any other party who may be responsible for paying for my treatment. (Section 112B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

SIGNATURE______________________________________ DATE ____________________