Regional Family Medicine

Please Circle Provider of Choice

***** MUST HAVE PHOTO ID (18 & Older) & INSURANCE CARDS TURNED IN WITH THESE FORMS *****

□ J. Gregory Elders M.D. □ George S. Lawrence M.D. □ Lonnie S. Robinson M.D. □ Andrea N. Bounds M.D.
□ Sharon Jamie Pritchard M.D. □ Alex S. Hagaman D.O. □ Ronald F. Bruton M.D.
□ Hannah G. McCarthy M.D.

Patient Information: (MUST BE COMPLETELY FILLED OUT)

Last Name:_____ First Name:_____ Middle Initial:_____

DOB:	**Social Security #:**	**Sex:** □Male □Female	**Email:**
Address:	**City:**	**State:**	**Zip:**
Please Circle Preferred Contact Method	**Home Phone:**	**Cell Phone:**	
Race: □American Indian or Alaska Native □Asian □Black or African American □Native Hawaiian or Other Pacific Islander □White □Other_____ □Decline **Ethnic Group:** □Hispanic or Latino □Non-Hispanic or Latino □Decline **Language:** □English □Spanish □Other_____			
DL #:	**DL Exp. Date:**	**State:**	**Marital Status:** □Single □Married □Divorced □Widowed
Spouse's Name:			
Patient's Employer:		**Employer Phone:**	
Spouse's Employer:		**Employer Phone:**	

Responsible Party Information: (MUST BE COMPLETELY FILLED OUT)

□ Check here if the Patient is the Responsible Party (Skip this Section)			
Relationship of Responsible Party to Patient: □Spouse □Parent/Guardian □Other_____			
Responsible Party:	**DOB:**	**Social Security #:**	
Home Phone:	**Cell Phone:**	**Work Phone:**	
Address:	**City:**	**State:**	**Zip:**
DL #:	**DL Expiration Date:**		

Insurance Information: (MUST BE COMPLETELY FILLED OUT)

(Please Present Insurance Cards to Receptionist) **Primary Insurance Company:**			
Name of Policy Holder:	**Policy Holder DOB:**	**Policy Holder SS#:**	
Insurance Policy #:	**Group #:**	**Copay:**	
If name of Patient is Different from the Policy Holders Please Indicate Relationship to Patient: □Child □Spouse □Other_____			
Secondary Insurance Company:			
Name of Policy Holder:	**Holder DOB:**	**Holder SS#:**	
Insurance Policy #:	**Group #:**	**Copay:**	
If name of Patient is Different from the Policy Holders Please Indicate Relationship to Patient: □Child □Spouse □Other_____			

Emergency Contact Information: (MUST BE COMPLETELY FILLED OUT)

Emergency Contact Name:	**Relationship:**	**DOB:**	**Phone:**
Emergency Contact Name:	**Relationship:**	**DOB:**	**Phone:**
Emergency Contact Name:	**Relationship:**	**DOB:**	**Phone:**
□Please Check and Date that HIPAA Policy was received Date:_____			

Assignment of Benefits * Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to REGIONAL FAMILY MEDICINE, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all cost of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____