Sonshine Family Health Clinic, LLC
Patient Registration Form   Please PRINT Clearly

Patient Information

Legal Last Name: ___________________ First Name: ___________________ Middle Initial: _____

Marital Status: _________________ Maiden Name: ______________ Alias: _________________

Date of Birth: ______________ Social Security #______________________ Sex: ____________

Physical Address: ____

Mailing Address, if different: ____

Home Phone: ______________ Cell Phone: ________________ Work Phone: ________________

E-mail Address: ________________________ Do you want online access to your records? _________

Employer: _____________________ Employer Address: __________________________________

Preferred Pharmacy & Location: _____________________________________ Phone: _____________

Emergency Contact Name: _______________________ Relationship__________ Phone: __________

Spouse or Partner Information

Name: ___________________________________ Date of Birth: _________ Phone: ______________

Employer: _____________________ Employer Address: __________________________________

Insurance Information

Primary Insurance: ______________________________ Phone Number: __________________

Insured Party's Name: __________________________________ Date of Birth: ______________

Policy #: _______________________ Group #: ___________ Relationship to Patient: __________

Secondary Insurance: ____________________________ Phone Number: __________________

Insured Party's Name: __________________________________ Date of Birth: ________________

Policy #: _______________________ Group #: ___________ Relationship to Patient: ___________

Living Will & Advanced Directive

Do you have a living will/advanced directive? ______

Do you need information about setting up a living will? _____

If Patient is a Minor

Father's Name: ________________________ SS#: _________________ Phone: ______________

Employer: ________________ Address: _______________________Occupation: ______________

Mother's Name: ______________________ SS#: _________________ Phone: ______________

Employer: ________________ Address: _______________________Occupation: ______________

Who is the custodial parent: __________________________________

Please read & sign below:
I have been offered the HIPAA Notice of Privacy Practices for Sonshine Family Health Clinic, LLC.
I hereby authorize the providers of Sonshine Family Health Clinic, LLC to furnish my insurance company all information requested. I hereby assign to Sonshine Family Health Clinic, LLC all money to which I am entitled for medical expenses relating to the services provided. I release the providers and Sonshine Family Health Clinic, LLC from all legal responsibility or liability that may arise from this authorization.
I willingly consent to the care I receive from the providers at Sonshine Family Health Clinic, LLC.
I understand that any credit balance on my account will remain unless specifically requested in writing.
I further understand that interest will be assessed at the rate of 1.5% per month (18% per annum) on all balances carried beyond 90 days.

Patient Signature: ____

Patient Name (printed): ____ Date: _______________

Disclosure Form

Of the persons living in your household or with whom you are associated, to whom may Family Health Care employees disclose your health information (such as appointment times, lab results, test results, or financial matters) if you are not available?

1. Please PRINT their name: ____________________ Relationship to you: ___________________

2. Please PRINT their name: ____________________ Relationship to you: ___________________

3. Please PRINT their name: ____________________ Relationship to you: ___________________

How would you prefer we contact you? □ Telephone, mail & e-mail are ok
□ Telephone Only-preferred phone #_____________
□ Mail Only-(envelope with our name & return address): Address _____________________________
____

□ E-mail Address: _________________________

Signature: ____________________________________ Date: _____________