

# FLAGSTAFF WALK-IN MEDICAL CARE

**Appointment Date:** \_\_\_\_\_

**PATIENT REGISTRATION**

## PATIENT INFORMATION

Patient #:	Gender:	Date of Birth:
Last Name:		Age
First Name:	Initial:	Social Security #:
Address:		Home Phone:
City, State, Zip:		Work Phone:

## RESPONSIBLE PARTY

Account #	Patient Relationship to Guarantor:		
Last Name:	Gender:	Marital Status:	
First Name:	Date of Birth:		
Address:		Social Security #:	
City, State, Zip:		Home Phone:	
Employer:	City, State Zip:		Work Phone:
Employer Address:			

## INSURANCE INFORMATION

<b>Primary Insurance:</b>		Policy/Subscriber:
Address:		Insured Policy ID:
City, State, Zip:		Group Number:
Plan Phone:		Date of Birth:
Effective Dates:		Patient Relationship to Subscriber:
<b>Second Insurance</b>		Policy Subscriber:
Address:		Insured Policy ID:
City, State, Zip:		Group Number:
Plan Phone:		Date of Birth:
Effective Dates:		Patient Relationship to Subscriber:

## PARENT/LEGAL GUARDIAN AND EMERGENCY CONTACT INFORMATION

Parent/Legal Guardian Name:	<b>Emergency Contact:</b>
Address(if different than patient):	Address(if different than patient):
	Patient relationship to Contact:
Parent Home Phone:	Contact Home Phone:
Parent Work Phone:	Contact Work Phone:

## MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

•Payment in full is required at the time of service unless we are a participant with your prepaid plan. Today we will collect your plan's co-payment, deductible and non covered services. Your signature below authorizes us to disclose your information to your plan. Should your plan deny payment you will be responsible for payment. Accounts 30 days past due will incur a 1.5% per month (18% annum) service charge. We will add a \$25.00 charge for all returned checks.

•Our practice adheres to the standards set forth in the Notice of Privacy Practices we have presented you.  
 •Your signature below signifies (1) your understanding and willingness to comply with these policies (2) your authorization of medical benefits to be paid by your plan to us (3) your receipt of our Notice of Privacy Practices (4) Your authorization for us to contact you at any of the numbers/locations indicated on this form.

X \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature

•Do you Authorize us to release medical records to your other health care providers YES \_\_\_\_\_ NO \_\_\_\_\_.

•The telephone number that we can leave a detailed message is: \_\_\_\_\_