Ouachita Family Medicine

Patient Registration Information

Today's Date: _____ ⌈ New Patient ⌈ Information Change
Patient Name: _____ Date of Birth: _____
Address: _____ SS#: _____
_____
Home Phone: _____ Cell Phone: _____
E-Mail: _____
Marital Status: ⌈ Single ⌈ Married ⌈ Divorced ⌈ Widowed **Sex**: ⌈ Male ⌈ Female
Employer Name: _____ Work Phone: _____
Employer Address: _____
_____ Occupation: _____

Resp. Party: _____ Date of Birth: _____
_____ SS#: _____
_____
Home Phone:_____ Cell Phone: _____
Employer Name: _____ Work Phone: _____
Employer Address: _____
Occupation: _____

***Insurance Information*:**
Insurance #1: _____ Policy: _____
Insurance Address: _____ Group: _____
_____ Phone: _____
Policy Holder: _____ Date of Birth: _____

Insurance #2: _____ Policy: _____
Insurance Address: _____ Group: _____
_____ Phone: _____
Policy Holder: _____ Date of Birth: _____

Spouse's Name: _____ Work Phone: _____
Employer Address: _____ Spouse's SS#: _____
_____ Occupation: _____
Emergency Contact: _____ Emergency Contact #: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION AND CONSENT FOR TREATMENT:

I hereby authorization payment directly to the Physicians of the medical benefits, in any otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I also authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims. I understand that I shall be responsible for reasonable collection agency fees (50%) of the delinquent balance, attorney fees, court costs, or any fees incurred in an attempt to collect amounts I may owe.
The signature below gives consent for medical treatment for the above patient. In case of a minor, the signature is that of a parent or a guardian.

Patient Signature: _____ Date: _____