Healthlink Family Practice and Sports Medicine, Inc.
Registration Form

(Please Print)

Today's Date:			**Preferred Language:** ☐ English ☐ Other: _____		
Email Address: _____			**Preferred method of contact** ☐ Home Phone ☐ Cell Phone		
Patient's Last Name: **First Name:** **Middle:**			☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	**Marital Status (circle one)** Single / Married / Divorced / Separated / Widowed	
Nickname	**Maiden Name**	**Suffix (circle one)** I / II / III / Jr / Sr Other:_____	**Gender (circle one)** Male / Female	**Date of Birth:** ____/____/____ **Social Security Number:** _____/_____/_____	
Street Address:			**P.O. Box:**		
City:	**State:**	**Zip Code:**	**Phone:** (Home)_____ (Cell)_____		
If patient is a minor, name of parents or guardian:			**Name of Spouse & Emergency Contact Phone #:**		
Employer Name & Address:		**Occupation:**		**Employer Phone Number:**	

In Case of Emergency:

Name of local friend or relative (not living at same address)_____

Relationship to patient:_____ Home Phone:_____ Other Phone:_____

How Did You Learn About Our Practice?

☐ Internet Search ☐ Friend ☐ Relative ☐ Co-Worker ☐ Mailer/Advertisement ☐ Physician Referral (who):_____

☐ Website ☐ Other Medical Facility:_____ ☐ Other:_____

Do You Consistently Use a Specific Pharmacy? ☐ **YES** ☐ **NO**

If so, what is the name and location of the pharmacy:_____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill: **First Name:** _____ **Last Name:** _____	**Address (if different than patient):**	**Contact Numbers:** **Home:** _____ **Cell:** _____ **Date of Birth:** _____/_____/_____
Is this person a patient here? ☐ YES ☐ NO		
Employer Name & Address:	**Occupation:**	**Employer Phone Number:**
Is this patient covered by insurance: ☐ **YES** ☐ **NO** ***CASH PAY PATIENTS: Monies collected prior to appointment may not reflect total charges for services rendered.***		
Name of primary insurance coverage:	**Group #:**	**Policy/ID #:** / **Co-Payment:** **$**
Subscriber's Name: First Name: _____ Last Name: _____	**Subscriber's Date of Birth:** _____/_____/_____ **Subscriber's Social Security #:** _____-_____-_____	**Patient's relationship to Subscriber:** ☐ Self ☐ Spouse ☐ Child ☐ Other: _____
Name of secondary insurance coverage (if applicable):	**Group #:**	**Policy/ID #:** / **Co-Payment:** **$**
Subscriber's Name: First Name: _____ Last Name: _____	**Subscriber's Date of Birth:** _____/_____/_____ **Subscriber's Social Security #:** _____-_____-_____	**Patient's relationship to Subscriber:** ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

The above information is true to the best of my knowledge. I authorize payment of insurance benefits to be paid directly to the physician. I understand I am responsible for any charges for services rendered not covered by insurance. I also understand that should I become delinquent on my account and my account is turned over to a collection agency that I am responsible to pay collection fees and/or attorney fees assessed which could total up to 50% of the dollar amount turned over to the collection agency.

I authorize HEALTHLINK FAMILY PRACTICE & SPORTS MEDICINE, INC. to release any information concerning my (or my child's) healthcare and treatment provided for the purpose of evaluating and processing of claims for insurance benefits.

_____ DATE: _____

(Signature of patient / guardian of minor)