HEARTLAND FAMILY MEDICINE, P.C.
PATIENT REGISTRATION FORM (PLEASE PRINT)

PATIENT INFORMATION

Patient's Name ____ Date _____________ Social Security # ______ - ______ - ______

P.O. Box __________ Street ________________________ City __________________________ State ______ Zip _____________

Birth Date ___________ Age _________ Sex _________ Marital Status _________________ Phone ________ ________ ________

Cell Phone ________ ________ ________ Employer __________________________ Work Phone ________ ________ ________

GUARANTOR (PERSON RESPONSIBLE FOR PAYMENT)

Same As Patient ☐ or Guarantor's Name _____________________________________ Social Security # ______ - ______ - ______

P.O. Box __________ Street ________________________ City __________________________ State ______ Zip _____________

Birth Date ___________ Age _________ Sex _________ Marital Status _________________ Phone ________ ________ ________

Cell Phone ________ ________ ________ Employer __________________________ Work Phone ________ ________ ________

Relationship To Patient: Spouse ☐ Parent ☐ Guardian ☐ Child ☐ Grandchild ☐ Other Please Explain _________________

PRIMARY INSURANCE (MEDICAID PATIENTS MUST PRESENT THEIR CARD EACH VISIT)

Name of Insurance Provider ____ Will Provide Current Copy of Card ☐ Or:

Effective Date __________ Policy Holder: Guarantor ☐ Other Please Provide Name ______________________________________

Policy Number ______________________ Group # _______________________ Insurance Phone ________ ________ ________

P.O. Box __________ Street ________________________ City __________________________ State ______ Zip _____________

SECONDARY INSURANCE

Name of Insurance Provider ____ Will Provide Current Copy of Card ☐ Or:

Effective Date __________ Policy Holder: Guarantor ☐ Other Please Provide Name ______________________________________

Policy Number ______________________ Group # _______________________ Insurance Phone ________ ________ ________

P.O. Box __________ Street ________________________ City __________________________ State ______ Zip _____________

EMERGENCY CONTACT

Name _____________________________________ Relationship To The Patient ____

Phone ________ ________ ________ Work Phone ________ ________ ________ Cell Phone ________ ________ ________

P.O. Box __________ Street ________________________ City __________________________ State ______ Zip _____________

AUTHORIZATION (PLEASE READ BEFORE SIGNING)

I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative. I understand that Heartland Family Medicine ("HFM") will share patient health information according to federal and state law for treatment, payment, and operations. I understand the patient and/or guarantor are responsible for all charges incurred, regardless of insurance status. I authorize my insurance providers to pay HFM for charges incurred. I understand that it is the policy of my insurance provider and HFM to collect my co-pay, if applicable, at the time of service.

Patient Signature ____________________________________ **Date** _______________ **Or:**

Parent/Legal Signature ________________________________ **Relationship** ____________________ **Date** ________________