

**WILDWOOD FAMILY CLINIC, S.C.  
PATIENT REGISTRATION FORM**

**PATIENT'S NAME:** \_\_\_\_\_  
Last Name First Name Middle Initial

Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ M \_\_\_\_ F SSN \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Status \_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Widowed Primary Physician \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Name \_\_\_\_\_ Cell Phone (if appropriate) \_\_\_\_\_

Employer Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_

**IF PATIENT IS MINOR, NAME OF PARENT OR GUARDIAN**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

SSN \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer Name \_\_\_\_\_ Address \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

**SECONDARY INSURANCE**

Insurance \_\_\_\_\_

Subscriber # \_\_\_\_\_

Group # \_\_\_\_\_

Effective Date \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex ( M ) ( F )

Relationship to Patient \_\_\_\_\_

Policy Holder Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Insurance \_\_\_\_\_

Subscriber # \_\_\_\_\_

Group # \_\_\_\_\_

Effective Date \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex ( M ) ( F )

Relationship to Patient \_\_\_\_\_

Policy Holder Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

**AUTHORIZATION TO RELEASE AND ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY**

*All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. This includes balances beyond the "usual and customary" reimbursement by insurance companies. If the patient is uninsured, it is customary to pay for services when rendered unless other arrangements have been made in advance.*

I request that payment of authorized Medicare/Other insurance company benefits be made on my behalf to the Wildwood Family Clinic, S.C. for any services furnished me by that party. I authorize any holder of medical information about me to release to the Social Security Administration and Centers for Medicaid & Medicare Services or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify my health care provider of any other party who may be responsible for paying for my treatment. (Section 112B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_