|  |  |
| --- | --- |
| **Scholls Family Care Patient Registration Form** | |
| |  |  | | --- | --- | | **Patient Information** | | | Last Name: | | | First Name: | | | Middle Initial: Suffix: | | | DOB: | | | Sex: **□ M □ F** | SSN: | | Marital Status: □ Married □ Single □ Other | | | Do you need an interpreter? YES (circle) | | | Race: □ **Hispanic or Latino** | | | Address: | | | City, State: | | | Zip Code: | | | Home Phone: | | | Mobile Phone: | | | Work Phone: | | | Email Address: | | | |  | | --- | | **Emergency Contact Information** | | Name: | | Phone: | | Relationship: | | **Guarantor Information (If other than patient)** | | Name: | | Address: | | City, State, Zip: | | Phone: | | **Coordinating Care Information** | | Employer: | | Primary Care Doctor: | | Referring Doctor: | | Pharmacy Name: | | Pharmacy Phone: | |
| Is your visit related to a **Workers Compensation** Claim? YES or NO (circle one) | |
| Is your visit related to an **automobile accident**? YES or NO (circle one) | |
| Is patient care or financial affairs managed by a parent or guardian? YES or NO (circle one) | |
| |  | | --- | | **Primary Insurance** | | Insurance Company: | | Insurance ID Number: | | If you have **Oregon Health Plan** – Medicaid -  **YOU ARE DONE. Sign Below** | | Group Number if applicable: | | **Is patient the subscriber (policyholder) on this insurance?**  **YES** – skip to Secondary Insurance if applicable.  **NO** – Please provide **policyholder information** below: | | Name: | | Relationship: Spouse Child Other | | DOB: | | Telephone: | | Address: | | |  | | --- | | **Secondary Insurance** | | Insurance Company: | | Insurance ID Number: | | Group Number if applicable: | |  | |  | | **Is patient the subscriber (policyholder) on *this* insurance?**  **YES** – *DONE*, thank you.  **NO** – Please provide **policyholder information** below: | | Name: | | Relationship: Spouse Child Other | | DOB: | | Telephone: | | Address: | |
| **Please be sure to give all insurance cards to the receptionist.** | |
| **Assignment of Benefits, Release of Information, and Agreement to Pay** | |
| **I hereby authorize payment directly to the physician for medical services provided. I hereby authorize the release of any medical information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by the insurance company.**  **Date: Signature of Responsible Party:** | |