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| **Scholls Family Care Patient Registration Form** |
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| **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: |

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| **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: |

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| 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) |
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| **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: |

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| **Secondary Insurance** |
| Insurance Company: |
| Insurance ID Number: |
| Group Number if applicable: |
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| **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: |

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| **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:** |