Patient Registration

Walk In Clinic
State of Franklin
HEALTHCARE ASSOCIATES

Patient Information

First Name _____ M.I. _____ Last Name _____

Birthdate _____ ☐Male ☐Female Age _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Telephone Number (_____)_____ Cell Telephone Number (_____)_____ Work Telephone Number (_____)_____

Email Address: _____ Patient Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Employer's Name _____ Employer's Address _____ City/State _____ Employer's Telephone # _____

Primary Care Physician _____

Referral Source - How did you hear about us? ☐ Physician _____ ☐ Yellow Pages
☐ Billboard ☐ TV Commercial ☐ Internet ☐ Facebook ☐ Newspaper ☐ Signs
☐ Family/Friends ☐ Other (Please Specify): _____

Name of Spouse or Parent _____ Telephone # _____ Employer of Spouse or Parent _____

NAME OF FINANCIAL RESPONSIBLE PARTY AND ADDRESS _____ SSN# _____

In Case of Emergency Notify _____ Relationship _____ (_____)_____ Emergency Contact Telephone Number

Insurance Information

Primary Insurance _____ Identification Number _____ Group Number _____

INSURANCE SUBSCRIBER'S NAME: _____ RELATION TO PATIENT: _____

SUBSCRIBER'S DATE OF BIRTH: _____ ☐Male ☐Female SUBSCRIBER'S SOCIAL SECURITY #: _____

SUBSCRIBER'S EMPLOYER _____

Secondary Insurance _____ Identification Number _____ Group Number _____

INSURANCE SUBSCRIBER'S NAME: _____ RELATION TO PATIENT: _____

SUBSCRIBER'S DATE OF BIRTH: _____ ☐Male ☐Female SUBSCRIBER'S SOCIAL SECURITY #: _____

Authorization

I hereby authorize State of Franklin Healthcare to release to the above companies (or their representatives) any information including the diagnosis and the records of any treatment or examination rendered to me. I authorize and request the above named companies to pay directly to State of Franklin Healthcare any benefits due for their medical or surgical services rendered to me. I permit a copy of these authorizations to be used in place of the original. I understand that I am responsible for payment of any and all charges incurred by me.

Date _____ Signature of Patient or Responsible Party _____