Woodson Family Medical Clinic

Patient Registration Form

Patient Information

Patient Name: First _____ *MI* _____ *Last* _____

Address _____ *APT* _____

City _____ *State* _____ *Zip* _____

Home Phone _____ *Cell* _____ *Alternate* _____

Date of Birth _____ *Sex* _____ *Marital Status: Married Single Divorced Widowed Separated*

Social Security Number _____ *DL#* _____

Employer information

Employer _____ *Phone* _____

Employer Address _____

City _____ *State* _____ *Zip* _____

Insurance information

Subscriber Name _____ *Date of Birth* _____

SS# _____ *Relationship to Patient* _____

Employer _____ *Phone* _____

Employer address _____

Name of insurance company _____

Claims Address _____ *City* _____ *State* _____ *Zip* _____

Policy Number _____ *Group Number* _____

Emergency Contact

Name _____ *Relationship* _____

Address _____ *APT* _____

City _____ *State* _____ *Zip* _____

Home Phone _____ *Cell* _____ *Alternate* _____

Advanced Directive

I have an advanced directive: *Yes* *No*

Privacy Practice (HIPPA)

I have reviewed The Privacy Practice, which explains to me how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

*Name of Patient*_____

*Signature of Patient or Representative*_____

*Date*_____*Relationship to patient* _____

Assignment of Benefits

I hereby give lifetime authorization of payment of insurance benefits to be made directly to Dr. Stephen Woodson or Woodson Family Medical Clinic and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my Insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

*Signed*_____*Date*_____

I authorize the release of Medical information for the purpose of processing my medical claims. I understand that I am financially responsible for any balance not covered by my insurance company.

*Signed*_____*Date*_____