Southwest Family Practice

Patient Registration

Patient: (Last)___________________(First)_________________(MI)______DOB:_____

Address: (Street)_____________________(Aptt No)______(State)_____(Zip)_________

SS # ____-___-____ Phone: (H)______-______-________(C)______-______-__________

Gender: M___F___ Email address:____

Race:__________Ethnicity:_________Marital Status:__________

Preferred Pharmacay:_________________Address:_______________________________

Responsible Party:____

Address (if different from Patient):____

Responsible Party Date of Birth:___________Responsible Party SS#______-____-_______

Employer:____________________________ Work Phone:__________________________

Emergency Contact:____________________Relationship:_________Phone:____________

Medical History (Please Circle):

Anemia Anxiety Arthritis Asthma Cancer Depression Diabetes Elevated Cholesterol Emphysema/COPD Glaucoma Gout Heart Attack Hepatitis High Blood Pressure Hypoglycemia Parkinson's Disease Seizures Sinus/Allergies Stroke Thyroid Problems Tuberculosis Irregular Heart Beat Kidney Disease Other:

Surgeries: Appendix Cataracts Coronary Bypass Gall Bladder Hernia Hysterectomy Tonsils Tubal Ligation Vasectomy Other:

Consent to Treat:

I authorize treatment deemed necessary by Health Care Providers and/or his/her designee(Parent or Guardian if patient is a minor)____

Payment is required at the time services are rendered unless other arrangements have been made. A copy of your driver's license and valid insurance card is required when filing arrangements have been made.

I request that payment of authorized Medicare/other insurance company benefits be made on my behalf to Southwest Family Practice for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefit apply. I authorize any holder of medical and other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers of any other insurance company any information needed for this or a related Medicare/other insurance company claims. I understand my signature requests that payment be made directly to the provider and authorities release of medical information necessary to process the claims. If item of the HCFA-1500 claim form is completed my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/other insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/other insurance company as the full charge and the patient will be responsible only for the deductible/coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination.

Patient Signature: (Parent or Guardian if patient is a minor)_____________________Date_________