Vance Family Medicine Registration Information

Date: _____ / _____ / _____ **Email Address:** _____

Patient Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Responsible Party (if Patient is Minor): _____

Address: _____

Cell Phone: _____ **Home Phone:** _____

Sex: ☐ Male ☐ Female **Date of Birth:** _____ / _____ / _____ **Age:** _____

Marital Status: ☐ Married ☐ Single ☐ Divorced **Social Security #:** _____

Race (Please Check One): ☐ Caucasian ☐ African Descent ☐ Asian Descent ☐ Latino ☐ Latino / Hispanic ☐ Other Ethnicity

Preferred Language: _____

Preferred Doctor or Physician Assistant: _____

Patient Employed by: _____ **Business Phone:** _____

Who is responsible for this account? _____ **Relationship to Patient:** _____

Do you have medical insurance? _____ **Name of Insurance Company:** _____

Name of Policy Holder: _____

Policy Holder's Date of Birth: _____ / _____ / _____ **Policy Holder's Social Security #:** _____

Policy Holder's Employer: _____

Emergency Contact (Name): _____ **Phone (Not Your Own):** _____

With whom may we share information about your account? _____

_____

With whom may we share your medical records or test results? _____

_____

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any commercial insurance agency, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I have received notice of Vance Family Medicine's privacy practices.

Signature: _____