

Patient Registration Information

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION

Marital Status: Single Married Divorced Widowed **Sex:** Male Female

Last name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Social Security #: ____-____-____

Home Phone: (____) _____ Cell Phone: (____) _____
OK to leave a message that includes medical information on your voicemail or answering machine? Yes No

Address: _____ Apt. #: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Address: _____ Ph. No. _____

Preferred Language: _____ Race: _____ Ethnicity: _____ Religion: _____

Full Time College Student: Yes No Who is responsible for payment of your medical bills? Self Father Mother Spouse

PARENT OR SPOUSE INFORMATION

Sex: Male Female

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Social Security #: ____-____-____

Home Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Address: _____ Ph. No. (____) _____

OTHER PARENT/CUSTODIAL PARENT

Sex: Male Female
(Only enter non-custodial parent if that parent is the insurance carrier)

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Social Security #: ____-____-____

Home Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Address: _____ Ph. No. _____

EMERGENCY CONTACT (OUTSIDE OF HOUSEHOLD)

Relationship to Patient: Parent Sibling Child Other: _____

Name: _____ Address: _____ Ph. No. h) (____) _____
c) (____) _____

SPOUSE/PARENT RELEASE

In my absence I give consent for medical information (such as lab or x-ray results) to be given to:

(name of spouse, parent, other) Signed _____ Date _____
(your signature)

ASSIGNMENT AND RELEASE: I hereby authorize my Insurance Benefits to be paid directly to Norfolk Family Medicine, P.C. and understand that I am financially responsible for all charges whether or not they are covered by my insurance. I also authorize Norfolk Family Medicine, P.C. to release any medical information necessary to process insurance claims. Should a referral be made by any NFM Medical Provider for my continued care I authorize disclosure of pertinent medical records.

Signed (Self/Parent/Guardian) _____ Date _____

Print Name _____