Date: ___/___/___

HOMA
FAMILY MEDICINE

Registration Form

Personal Information

Patient Name: _____

D.O.B: ___/___/___ **Age:** _____ **Gender:** _____

Address: _____

_____

_____

Phone: _____ **(home)** _____ **(cell)** _____ **(work)**

Email: _____

Occupation: _____

Referring Physician: _____

Emergency Contacts

Name: _____ **Relationship:** _____

Address: _____

Phone: _____ **Email:** _____

Name: _____ **Relationship:** _____

Address: _____

Phone: _____ **Email:** _____

Date: ___/___/___

HOMA
FAMILY MEDICINE

Insurance Information

Insurance Name: _____

Subscriber's Name: _____

Insured ID #: _____ **Group #:** _____

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Authorization

I hereby authorize assignment of my insurance rights and benefits directly to the physician/ physician assistant for services rendered. I understand that I am financially responsible for any balance not paid by my insurance company. I authorize the physician/physician assistant to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance inquiries.

Patient Signature: _____ **Date:** _____