

## REGISTRATION INFORMATION

Full Legal Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

### IF UNDER 18 YRS OF AGE:

Responsible party name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Can we discuss your medical case with another person? \_\_\_Y\_\_\_N Name: \_\_\_\_\_

Can we leave a detailed message on answering machine? \_\_\_Y\_\_\_N

How did you hear about Great West Family Care: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Telephone: \_\_\_\_\_

### PRIMARY INSURANCE:

Subscriber Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

### ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information related to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for service to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim

I \_\_\_\_\_ hereby authorize \_\_\_\_\_

To pay and hereby assign directly to Great West Family Care, PC all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Great West Family Care, PC will be credited to my account, in accordance with the above said assignment.

\_\_\_\_\_  
Authorized Signature of Subscriber

\_\_\_\_\_  
Date