**UFPA - PATIENT REGISTRATION FORM Date**

**Patient:**  Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ste/Apt. \_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_ State \_ Zip\_\_\_\_\_\_\_\_

Home Phone # Work Phone # Cell Phone #

Preferred Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_ Marital Status M S D W

**Ethnicity-** **Choose One □** Hispanic/Latino **□** Not Hispanic/Latino □ Unknown □ Declined **Race \_**\_\_\_\_\_\_\_\_\_\_ Primary Language \_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone/Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation Who referred you to our office?

Name of Spouse Spouse's Telephone #

Local Emergency Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Daytime Phone #  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party for Minors:**

Last Name First Name Middle

Address Suite/Apt.

City State Zip

Home Phone # Work Phone # Cell Phone #

**Insurance Information:**

Who is your PCP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Company

Policy Holder Relationship to Patient

Policy Holder DOB Policy Holder's SSN

Do you have a Secondary Insurance Company Yes No

**Authorization to Release Information:** I hereby authorize Urban Family Practice to release my information acquired in the course of examination of treatment. (For Insurance/Medicare Purposes)

**\*SIGNATURE: \_\_\_\_\_**

**Authorization to Pay Benefits to Physician:** I hereby assign payment to Urban Family Practice for services covered by Insurance/Medicare. I understand that I am personally responsible for all changes and payment in full is due no later than 60 days from the date of service. \***SIGNATURE:**

**Authorization for Treatment:** I give consent for **myself/son/daughter** to undergo examination, lab-work, x-ray and treatment by Urban Family Practice. \***SIGNATURE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Receipt of Notice Privacy Practices For New Patients \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy. By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below. **\*SIGNATURE**  **DATE**

***Fees for services are payable at the time service is rendered. We will be happy to discuss fees with you in the office. We charge for missed appointment without 24-hour cancellation. Cancellation notice must be made during regular office hours. It is your responsibility to be aware of coverage limits within your insurance plan. If you are not satisfied with payment on a claim, contact your insurance company.***