WALK-IN CLINIC

Patient Registration

(Please Print)

State of Franklin Healthcare Associates

Patient Information

_____ _____ _____

First Name M.I. Last Name

_____ ☐Male ☐Female _____ _____

Birthdate Age Social Security Number

_____ _____

Address City State Zip

(_____)_____(_____)_____(_____)_____

Home Telephone Number Cell Telephone Number Work Telephone Number

Email Address: _____ **Patient Marital Status:** ☐Single ☐Married ☐Divorced ☐Widowed

_____

Employer's Name Employer's Address City/State Employer's Telephone #

_____

Primary Care Physician

Referral Source - How did you hear about us? ☐ **Physician** _____ ☐ **Yellow Pages**
☐ **Billboard** ☐ **TV Commercial** ☐ **Internet** ☐ **Facebook** ☐ **Newspaper** ☐ **Signs**
☐ **Family/Friends** ☐ **Other (Please Specify):** _____

_____ _____

Name of Spouse or Parent Telephone # Employer of Spouse or Parent

_____

NAME OF FINANCIAL RESPONSIBLE PARTY AND ADDRESS SSN#

_____ _____ (_____)_____

In Case of Emergency Notify Relationship Emergency Contact Telephone Number

Insurance Information

_____ _____

Primary Insurance Identification Number Group Number

INSURANCE SUBSCRIBER'S NAME: _____ **RELATION TO PATIENT:** _____

SUBSCRIBER'S DATE OF BIRTH: _____ ☐Male ☐Female **SUBSCRIBER'S SOCIAL SECURITY #:** _____

SUBSCRIBER'S EMPLOYER _____

_____ _____

Secondary Insurance Identification Number Group Number

INSURANCE SUBSCRIBER'S NAME: _____ **RELATION TO PATIENT:** _____

SUBSCRIBER'S DATE OF BIRTH: _____ ☐Male ☐Female **SUBSCRIBER'S SOCIAL SECURITY #:** _____

Authorization

I hereby authorize State of Franklin Healthcare to release to the above companies (or their representatives) any information including the diagnosis and the records of any treatment or examination rendered to me. I authorize and request the above named companies to pay directly to State of Franklin Healthcare any benefits due for their medical or surgical services rendered to me. I permit a copy of these authorizations to be used in place of the original. I understand that I am responsible for payment of any and all charges incurred by me.

_____ _____

Date Signature of Patient or Responsible Party