

Express Care Clinic/West Lincoln Family Medicine
New Patient Registration

Patient Information (Please Print)							
First Name	MI	Last Name	Date of Birth	Gender	Social Security Number		
Address			Apt #/Unit	City		State	Zip Code
Home Phone		Cell		Work			
Occupation/Employer				Email			
Marital Status (Please circle one) Single Married Divorced Partners Separated Widowed	Race (Please circle one) American Indian Alaskan Native Asian Black/African American Pacific Islander White/Caucasian Other Unknown		Ethnicity (Please circle one) Hispanic Latino Not Hispanic or Latino Unknown		Language (Please circle one) English Arabic Chinese Kurdish Russian Spanish Vietnamese Other: _____		
Pharmacy							
Name and Location							
Parent/Guardian Information (if patient is 19 years of age or under)							
First Name	MI	Last Name	Date of Birth	Gender	Social Security Number		
Address (same as patient)			Apt #/Unit	City		State	Zip Code
Relationship to Patient:							
Emergency Contact (Closest friend or relative NOT living with you)							
Name		Phone Number			Relationship to Patient		
Insurance and Billing Information *All information is required*							
<i>Please be aware that if you do not provide all required information, we will not be able to file properly with your insurance company and you will be responsible for payment for today's services.</i>							
Primary Insurance							
Insurance Company Name					Co-Pay		
Member ID Number				Group ID Number			
Policy Holder's Name		Relationship to Patient		Policy Holder's Date of Birth		Policy Holder's SSN	
Secondary Insurance							
Insurance Company Name							
Member ID Number				Group ID Number			
Policy Holder's Name		Relationship to Patient		Policy Holder's Date of Birth		Policy Holder's SSN	
Do you have additional insurance or supplements? Y <input type="checkbox"/> N <input type="checkbox"/>							
Policy Information:							
Is your condition related to employment or an auto accident? Y <input type="checkbox"/> N <input type="checkbox"/>							
Claim Number:							

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Power of Attorney Held By (If applicable, please provide a copy for your chart.)

Name

Address	Phone
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Living Will (If applicable, please provide a copy for your chart.)

Attorney Name	Firm
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Address	Phone
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Notice of Privacy Practices

I have been offered a copy of Express Care Clinic/West Lincoln Family Medicine’s privacy practices.

Signature: _____ Date: _____

My signature below gives permission for Express Care/West Lincoln Family Medicine to access the electronic prescription history for the patient.

Signature: _____ Date: _____

Message Authorization

Representatives of Express Care Clinic/West Lincoln Family Medicine are allowed to leave any and all information regarding my status as a patient on my voice mail, answering machine, or email account. I realize this information may include pertinent health status and/or financial information.

Signature: _____ Date: _____

Express Care Clinic/West Lincoln Family Medicine may communicate information to the following people regarding my health status as needed.

Name:	Phone Number:	Relationship to Patient:
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Name:	Phone Number:	Relationship to Patient:
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Do **NOT** leave a message (check box if applicable)

Signature: _____ Date: _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me, or, on my behalf, to Express Care Clinic/West Lincoln Family Medicine for any services furnished to me by its physician. I authorize my holder of medical information to be released to the Centers for MEDICAID and MEDICARE services and its agents any information needed to determine these benefits or the benefits payable for related services.

Secondary Insurance Benefits Authorization

I hereby authorize payment of Medigap and /or Secondary insurance benefits to Express Care Clinic/West Lincoln Family Medicine for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

Signature: _____ Date: _____

Payment Authorization

I hereby authorize payment directly to Express Care Clinic/West Lincoln Family Medicine, if any, otherwise payable to me for services performed by the medical clinic not to exceed the reasonable and customary charge for those services. I understand the provider’s charge may exceed the private insurance carrier payment, and if greater than such payment, I will be responsible for that amount. This balance may amount to deductible, co-insurance, non-covered services and /or supplies. I understand my co-payment, if any, is due and payable at the time of service and that I may be charged a late fee for the failure to pay at the time of service. I understand there is a \$30 return check fee.

Signature: _____ Date: _____

Release of Information

I hereby authorize Express Care Clinic/West Lincoln Family Medicine to release any information required in the course of my examination or treatment to my insurance and/or other entities for continuity of care.

Signature: _____ Date: _____