CORNERSTONE FAMILY MEDICINE of Greer

New Registration _____

PATIENT REGISTRATION FORM

Registration Update _____

Welcome to our office! Please fill out this form **completely** in legible print and black ink.

PATIENT INFORMATION

Full Name: _____ **Nickname:** _____
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Date of Birth: _____ **SSN:** _____ **County:** _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____
Email Address: _____ **Language:** _____ **Drivers License#:** _____
Race: _____ **Ethnicity:** _____ **Gender:** Male Female (Circle one)
Marital Status: SINGLE MARRIED WIDOWED SEPARATED DIVORCED (Circle one)

I authorize Cornerstone Family Medicine to disclose my **medical information** to the following people:

Name:	Relationship:	Phone Number:
_____ (Emergency Contact)	_____	_____
_____	_____	_____
_____	_____	_____

I acknowledge receipt of the CFM's Notice of Privacy Practice Policy: _____ INITIAL
I acknowledge receipt of the CFM's Notice of Financial Policy: _____ INITIAL

INSURANCE INFORMATION Please give your insurance card(s) to the receptionist

PRIMARY Insurance: _____
Name of Policy Holder: _____ **Date of Birth:** _____ **SSN:** _____
Subscriber ID#: _____ **Group#:** _____
Patient's Relationship to Policy Holder: SELF SPOUSE CHILD OTHER: _____
(Circle one)

SECONDARY Insurance: _____
Name of Policy Holder: _____ **Date of Birth:** _____ **SSN:** _____
Subscriber ID#: _____ **Group#:** _____
Patient's Relationship to Policy Holder: SELF SPOUSE CHILD OTHER: _____
(Circle one)

RESPONSIBLE PERSON FOR THIS PATIENT

SELF or OTHER (Please circle one) If Other, please fill out information below. Complete as a parent or legal guardian for any patient 18 years of age or younger. If you have any questions, please see the receptionist.

Name of Responsible Person: _____ **Relationship to Patient:** _____
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Date of Birth: _____ **SSN:** _____
Home Phone: _____ **Work Phone:** _____
Is the responsible person a patient at our office? YES NO

ASSIGNMENT/RELEASE/CONSENT TO TREAT

Permission is hereby granted to healthcare providers within this practice to administer such testing, examinations, treatments, and procedures as are deemed necessary in the course of my care. Information about me necessary to substantiate my insurance claims may be released by the healthcare provider involved in my care. I authorize payment directly to the provider's office of all insurance benefits otherwise payable to me for services rendered. I certify the above information is accurate. I understand that I am financially responsible for all services rendered on my behalf or on my dependents not paid by my insurance, including services denied due to inaccurate insurance/demographic information.

_____ _____
Signature of Patient/Parent or Legal Guardian of a Minor Today's Date