Family Care Network Patient Registration Form

Name:_____ DOB: _____
Preferred name: _____ Legal sex: _____
Address: _____ Sex at birth *(if different)*: _____
City, State, Zip: _____
Phone: Home: _____ Mobile: _____ Work: _____
Email address: _____
Employer: _____ Occupation: _____

Optional:
Pronouns: _____ Gender Identity: _____

GUARANTOR (person responsible for charges):
Complete this section for patients under age 18. All patients 18+ are their own guarantor, with limited exceptions.
Name: _____ Phone: _____
Address: _____ City, State, Zip: _____
Employer: _____

PRIMARY INSURANCE:
Insurance Company:_____ ID #: _____
Subscriber's Name: _____ Group #: _____
Subscriber's Date of Birth: _____ Patient Relationship to subscriber:
Subscriber's Phone # _____ _____

SECONDARY INSURANCE:
Insurance Company:_____ ID #: _____
Subscriber's Name: _____ Group #: _____
Subscriber's Date of Birth: _____ Patient Relationship to subscriber:
Subscriber's Phone # _____ _____
If Secondary or Third insurance is Medicare, please fill out the Medicare Coordination of Benefits Questionnaire.

THIRD INSURANCE:
Insurance Company:_____ Insured ID: _____
Subscriber's Name: _____ Insured G#: _____
Subscriber's Date of Birth: _____ Patient Relationship to subscriber:
Subscriber's Phone # _____ _____

Patient Contact #1:
Name: _____
Address: _____
Phone: _____
Relationship to patient: _____

Patient Contact #2:
Name: _____
Address: _____
Phone: _____
Relationship to patient:_____

I verify that this address, phone, guarantor, and insurance is correct. I authorize my insurance benefits be paid directly to the health care provider. I am financially responsible for any balance due. I also authorize the health care provider or insurance company to release any information required for this claim. MEDICARE: I understand my provider agrees to accept the Medicare allowed charge as the full charge, and I am only responsible for the deductible, co-insurance and non-covered services.

Signature: _____ Date: _____
Patient or legally authorized individual signature. Signature required for FCN to bill insurance.

Print Name: _____