KERNERSVILLE PRIMARY CARE
REGISTRATION FORM

(Please Print)

Today's date:	E- Mail address :

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation: Cell Phone: ( )	Employer: Ethnicity:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

DO YOU HAVE A PHARMACY YOU WOULD LIKE US TO SEND YOUR PRESCRIPTIONS TO**?**

Local: Mail Order:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Blue Cross	❑ Cigna	❑ Aetna	❑ United Healthcare	❑ MedCost
❑ Medicare	❑ Partners Medicare	❑ Medicare Complete UHC	❑ Medicaid	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable): Policy No:	Subscriber's name: Group no		

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Kernersville Primary Care

REGISTRATION FORM

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ALL PATIENTS PLEASE COMPLETE THIS SECTION

Kernersville Primary Care has my permission to speak with the following people regarding , medical treatment, test results and billing issues:

Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:

I give permission to Kernersville Primary Care to leave message at: ❑ Home ❑ Work

Is it OK to leave result - on your voice mail/answering machine? Yes No OR MAIL yes no OR By Email yes no

Patient/Guardian signature: *Date*

I give my permission for Dr. Kelly or his representative at Kernersville Primary Care to review my prescription history including pharmacy data through E prescribing.

Sign & date here : ____

PLEASE COMPLETE THE REST OF THE APPLICATION ONLY IF THE PATIENT IS A MINOR/CHILD

Patient's legal guardian last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

OTHER PARENT OR PERSON WHO HAS YOUR PERMISSION TO SEEK TREATMENT FOR THIS MINOR

Patient's legal guardian last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

PLEASE SIGN THE FOLLOWING STATEMENT

❑ I agree to accept financial responsibility or ❑ I have provided the attached legal document or notarized statement assigning financial responsibility for services provided by Kernersville Primary Care.

To: (Child's Name)

Your Signature: Date:

***** OPTIONAL " PERMISSION TO TREAT" AUTHORIZATION FOR TEENAGE CHILDREN**

I give Kernersville Primary Care permission to treat my teenage child if he/she seeks medical care or advice without my knowledge

Signature:	Relationship to patient:	Date: