CONFIDENTIAL
THE FAMILY DOCTOR, LLC
Registration Information

Where did you hear about us?
□ **Google Search** □**Google Ads** □**Direct Mail** □**Hawaii News Now**
□ **Insurance Website** □ **Facebook** □ **Referred by:**____________________
□ **Other**____________________

Date:___/___/___ **Email Address:**__________________ **Home Phone:** (___) _____-___________ **Cell Phone:** (___) _____-_____________

Patient's name: ____, ______________________________________ ____________
LAST *FIRST* *MI*

Street Address:____

City:____________________________**State:**____________________ **Zip:**______________________ **Race:**___________________

SSN: _______-_______-_______ **Gender** □ **Male** □ **Female** **Date of Birth:** ______/______/______

Ethnicity:____________________________ □ **Single** □ **Separated** □ **Married** □ **Divorced** □ **Widowed**

Name of Employer:____

Employer's Address:____

Occupation:____ **Business Phone:** (____)-_____-___________

Name of Spouse/ Responsible Party (if patient is minor):______________________________, ___________________, __________
LAST *FIRST* *MI*

Spouse/ Responsible Party Employed By: ____

Business Address:____

Occupation:____ **Business Phone:** (___)-____-____________

Spouse/ Responsible Party SSN:__________-__________-___________

Do you have medical insurance? □ **Yes** □ **No**

Name of Primary Insurance:_________________________________ **ID #:**__________________ **Group #:**___________________

Name of Secondary Insurance: ______________________________ **ID #:** __________________ **Group #:** ___________________

**** Required by HIPAA***
□ ***Pay my balance at the time of service*** □ ***Pay my balance upon receipt of first statement*** □ ***Make payment arrangement prior to rendering of services***

In case of emergency, who should be notified?________________________**Relationship:**_________________ **Phone:**(___)-______-_______

Name of relative or friend who can receive your medical information:_________________________________ **Phone** (___)-______-_______

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I,______________________________ hereby authorize ____
NAME OF INSURED *NAME OF INSURANCE COMPANY*
to pay and hereby assign directly **The Family Doctor, LLC** all benefits, if any, otherwise payable to me for his/her services as described in the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to **The Family Doctor, LLC** will be credited to my account, in accordance with the above said assignment.

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Authorized Signature of Subscriber ***Date***