Brashear Family Medical
Patient Registration Form

Patient Information

Name_____Age_____
First Middle Last

Social Security Number_____Date of Birth_____Sex: M or F

Race: (circle one or more) American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White
Other
Unknown

Ethnicity: (circle one) Hispanic or Latino
Not Hispanic or Latino
Unknown

Primary Language_____Driver's License #_____State_____

Marital Status: (circle one) Single Married Widowed Divorced Separated

Home Address_____
Street City State Zip

Home Phone_____Work Phone_____Cell Phone_____

Email Address_____

Occupation_____Employer_____

Employer Address_____

Emergency Contact Person_____Phone_____

Guarantor/Responsible Party if other than Self

Name_____Relationship_____
First Middle Last

Home Address_____
Street City State Zip

Home Phone_____Work Phone_____Cell Phone_____

Social Security Number_____Date of Birth_____Sex: M or F

Driver's License Number_____State_____

Occupation_____Employer_____

Employer Address_____

Please present all insurance upon returning this form or complete the following:

Primary Insurance_____ Address_____
Name of Insured_____ Relationship to Insured_____
Social Security #_____ Date of Birth_____
Member ID #_____ Group #_____
Employer_____ Work Phone_____

Secondary Insurance_____ Address_____
Name of Insured_____ Relationship to Insured_____
Social Security #_____ Date of Birth_____
Member ID #_____ Group #_____
Employer_____ Work Phone_____

Assignment of Benefits/Authorization for Treatment & Financial Agreement:
I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf. I understand that I am financially responsible for all charges not covered by my insurance and in the event of default, I agree to pay all costs of collection and reasonable attorney's fees.

Signature_____Date_____

Privacy Practices
Brashear Family Medical providers and staff are committed to securing the privacy of your health information. We are making available to you a copy of our Privacy Notice.

The following authorization is optional. I authorize the providers and staff of Brashear Family Medical to contact the following person/persons to discuss or disclose information regarding my appointments, insurance, test results, or other protected health information pertaining to my medical care. This authorization is considered valid unless and until written revocation is provided to Brashear Family Medical.

Name_____Phone_____

Name_____Phone_____

Name_____Phone_____

In the event Dr. Brashear or his staff needs to contact you or leave a message for you, what is your preferred method of contact? _____Home phone; _____Cell phone; _____Work phone

Medication Refill Requests
When you need a medication refill, please call your pharmacy and they will fax a refill request to us. Please allow 24-48 hours for refill authorizations.

Payment Policy
Payment for medical services is due at the time of service, including co-pays and deductibles if you have insurance coverage. You are responsible for services not covered by your insurance company. Please notify our office of any insurance changes.

Cancellation Policy
Please provide notice at least 24 hours in advance of any appointment that you must cancel or reschedule. Failure to do so may result in a cancellation fee.

A copy of the Brashear Family Medical Privacy Notice has been made available to me. Also, I agree to the above authorization to release medical information, and have read, understand and agree to the medication refill policy, the payment policy, and the cancellation policy as outlined above.

Signature_____Date_____