PATIENT REGISTRATION FORM

Name _____ Sex _____
First Middle Last

Mailing Address _____ Date of Birth _____

City _____ State ____ Zip _____ Social Sec. # _____

Home Phone _____ Work _____ Marital Status _____

Cell Phone _____ E-Mail Address _____

Usual Primary Care Provider _____

Language _____ Race _____ Ethnicity _____ (required by Federal Gov't.)

EMERGENCY CONTACT

Name _____ Phone _____ Relationship _____

EMPLOYER INFORMATION

Name _____ Phone _____

GUARANTOR or POLICY HOLDER INFORMATION

Name _____ Date of Birth _____ Soc. Sec. _____

Address _____ Phone _____

DISCLOSURE CONSENT *(in accordance with HIPAA Privacy Regulations)*

___ (check) I authorize SFM to leave messages on my voicemail about my medical issues/results.

I authorize the following individual(s) to receive verbal/written communications from Schreiber Family Medicine that may include health and/or account information about me:

Name _____ Relationship _____

NOTE: ***CURRENT INSURANCE CARDS MUST BE ON FILE AT TIME OF APPOINTMENT.***

ASSIGNMENT AND RELEASE OF INFORMATION

* I authorize treatment and access to my medication history by Schreiber Family Medicine.
* I have received my Notice of Privacy Information Practices.
* I hereby assign my insurance benefits to be paid directly to the physician.
* I authorize the physician to release any information required to process all claims.
* I authorize the physician to communicate with NM Statewide Immunization Info System.
* I understand that I am financially responsible for ALL non-covered services.

Signature _____ Date _____

Relationship if other than the patient _____

Rev. 12/22/2022