FAMILY FIRST SWIFTCARE

PATIENT REGISTRATION INFORMATION

Patient Name _____

Date of Birth _____ SSN: _____ Male/Female (circle)

Address _____ City/State: _____ Zip: _____

Home Phone: _____ Cell:_____ Work: _____

Occupation/Employer: _____ Address: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Care Physician: _____ Phone: _____

PARENT/GUARDIAN INFORMATION

Name _____

Date of Birth _____ SSN: _____ Male/Female (circle)

Address _____ City/State: _____ Zip: _____

Home Phone: _____ Cell:_____ Work: _____

INSURANCE INFORMATION

Insured Name: _____ Date of Birth _____ SS# _____

Primary Insurance: _____ ID#_____ Group#_____

Insurance Address: _____ Phone# _____

SECONDARY INSURANCE (if applicable)

Insured Name: _____ Date of Birth _____ SS# _____

Primary Insurance: _____ ID#_____ Group#_____

Insurance Address: _____ Phone# _____

I authorize the physicians of Family First SwiftCare to furnish to the above insurance carriers all information necessary to submit my claim for services, including any medical records that may be requested. I hereby assign all money received for my services to Family First and understand that I am financially responsible for any balances unpaid by my insurance. If treatment is provided to a minor, consent is authorized by a legal guardian.

_____ _____

RESPONSIBLE PARTY SIGNATURE DATE