Sunrise Family Clinic

Registration Form

Patient's Full Name: _____ **Previous Name(s):** _____

Address: _____

Phone: Home _____ **Cell** _____ **Work** _____ **Other** _____

E-mail (required): _____ **Date of Birth:** _____

Social Security Number: _____-____ -_____ **Employer Name:** _____

Please circle:

Sex: M - F **Ethnicity:** Hispanic or Latino - Not Hispanic or Latino - Declined

Race: American Indian - Alaska Native - Asian - African American - White - Other _____ - Declined

Preferred Language: English - Spanish - Other _____

Marital Status: Married - Single - Divorced - Widowed - Legally Separated - Partner

Employment Status: Full-Time - Part-Time - Not Employed - Self-Employed - Retired - Active Military

Student Status: Full-Time Student - Part-Time Student - Not a Student

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

□ Check here and skip to next section if information is same as patient

Responsible Party Full Name: _____ **Date of Birth:** _____

Social Security Number: _____-____ -_____ **Employer Name:** _____

Address: _____

Phone: Home _____ **Cell** _____ **Work** _____ **Other** _____

E-Mail Address: _____ **Date of Birth:** _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ **Relationship:** _____

Phone: Home _____ **Cell** _____ **Work** _____ **Other** _____

Do you have a living will, advanced directive, or healthcare power of attorney? Yes - No

If yes, please provide us with a copy to keep in your file.

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Name: _____

INSURANCE INFORMATION: **You must present your insurance card(s) to the front desk at check-in.**

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I understand that I, the undersigned patient and/or guarantor am responsible for charges incurred. It is a courtesy for Sunrise Family Clinic (SFC) to file my insurance, and I am responsible for my copay and/or percentage, and in the event my insurance company does not pay, I am responsible for the balance due. It is also my responsibility to be aware of or call my insurance regarding their requirements for prior authorizations or referrals. If these are not obtained before the visit, I am liable for any charges. If SFC is unable to obtain payment within a reasonable amount of time from the patient and/or guarantor, SFC reserves the right to place your account with a collection agency, which will leave me liable for additional expenses incurred if applicable. I have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to Sunrise Family Clinic. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits.

_____ _____

Patient or Responsible Party Signature Date