Patient Registration Form

Friendship Medical Center, P.A.
400 Ashville Avenue Suite 340 Cary, North Carolina 27518

eMail Address: _____

Patient Information

Patient Name (LAST, first, middle):	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Is this your LEGAL name: Yes No	
If not, what is your legal name?	
Any former names (including maiden)?	
Sex: ☐ Male ☐ Female Date of Birth:	
Home Address	
Street:	
City, State, Zip Code:	
Home Phone ( )	Mobile ( )

Insurance Information -- **REQUIRED**

Person responsible for bill:	Date of Birth:
Address (if different from patient)	
Home Phone ( )	Mobile ( )
Occupation:	Employer:
Employer Phone ( )	
Primary Insurance Plan (name): Patient's relationship to insurance subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____	
Subscriber's Name: Subscriber's SS# (optional): Subscriber's DOB:	Policy Number: Group Number: Copayment:
Secondary Insurance Plan (if applicable): Patient's relationship to insurance subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____	
Subscriber's Name: Subscriber's SS# (optional): Subscriber's DOB:	Policy Number: Group Number:

Emergency Contacts

(should not be someone living at same address; please list at least one contact)

Name	Relationship to patient	Home phone ( )	Work phone ( )	Mobile ( )
Name	Relationship to patient	Home phone ( )	Work phone ( )	Mobile ( )
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The above information is true to the best of my knowledge. I authorize insurance benefits be paid directly to physician & understand that I am financially responsible for insurance copay, deductible, all non-covered charges or remaining balance after insurance payments. I am responsible for understanding what is covered by my medical insurance. I authorize access to insurance coverage eligibility verification & all prescription history. Friendship Medical Center, P.A. or the insurance company may release any information required to process my claims.

Patient/Guardian Signature _____ Date: _____