North Raleigh Family Medicine
3331 Bandford Way, Suite 101 Raleigh, NC 27615
Tel: 919-841-4566 Fax: 919-841-4568

PATIENT REGISTRATION FORM (PLEASE PRINT)

Name:______________________________ DOB: ______________

Street Address: ______________________________

City: ____________________ State: __________ Zip Code:__________

Home #:______________ Work #:______________ Cell #:______________

Permission to leave message on voice mail: ☐ Yes ☐ No Language Preference______________

Preferred method of contact (please circle) H W C Email______________

Permission to leave medical information with______________________________

Social Security #: ______________ Sex: ☐ M ☐ F **Employer**: ______________

Place of Birth ______________________ **Type of Job**: ______________

Marital Status: ☐Single ☐Married ☐Other **Work Status**: ☐ Employed ☐ Student ☐ Other

INSURANCE INFORMATION (PLEASE PRINT)

Insurance Co: ______________________ Policy #: ______________

Address: ______________________ Group #: ______________

______________________ Phone #: ______________

Name of Subscriber: ______________________ ☐ **Check if Same as Patient**

Subscriber Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Date of Birth of Subscriber: ______/______/______ SSN of Subscriber: ______________

Employer of Subscriber: ______________________________

IF PATIENT IS MINOR; Person Financially Responsible(please print):______________

Current Specialist and/or Prior Providers Name(s), Address, Phone Number

1. ______________________________

Person to Contact in Case of Emergency (Name, Relationship, Contact #):

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I agree to be responsible for my medical expenses (including expenses not covered by my insurance company) and authorize the provider in charge to administer medical care as deemed necessary. I authorize the office of North Raleigh Family Medicine, to release my medical record(s) to my insurance company and to the North Carolina Office of Insurance and other government agencies for the purpose of processing my claim(s).

Signature: ______________________________ Date: ______/______/______
Signature of Patient, Parent, or Legal Guardian