

NEW PATIENT REGISTRATION FORM

Falls Family Practice, Inc.
1900 23rd Street
Cuyahoga Falls, OH 44223

HOME PHONE:* CELLULAR PHONE:* PAGER:

LAST NAME:* MIDDLE INITIAL:* FIRST NAME:*

DOB:* / / SSN:* M/F:*

STREET:* CITY:* STATE:* ZIP:*

PLEASE CHECK ONE: * Single Married Divorced Widowed Separated

If patient is a minor (under the age of 18):

GUARDIAN LAST NAME: FIRST NAME:

STREET: CITY: STATE: ZIP:

DOB: / / SSN:

INSURANCE INFORMATION

Policy Holder

LAST:* FIRST:* DOB:* / / M/F:*

STREET:* CITY:* STATE:* ZIP:*

Employer Information

NAME:* STREET:* CITY:* STATE:* ZIP:*

PHONE NUMBER:*

Insurance Company

NAME:* PHONE NUMBER:*

ADDRESS:* CITY:* STATE:*

ZIP:* MEMBER ID #:* GROUP #:*

Do you have a second Insurance Policy? Yes No

Second Policy Holder

LAST: FIRST: DOB: / / SSN:

Employer Information

NAME: STREET: CITY: STATE: ZIP:

Insurance Company

NAME: STREET: CITY: STATE:

ZIP: MEMBER ID #: GROUP #:

PLEASE READ - AUTHORIZATION FOR TREATMENT, INFORMATION RELEASE & ASSIGNMENT OF BENEFITS

I hereby request and consent to treatment and services provided by physicians at Falls Family Practice, Inc. and authorize payment directly to the physician of the Medical and/or surgical benefits, if any, otherwise payable to me by Medicare or any other insurance company for his services. I assume responsibility for any unpaid balance including non-covered services except as limited by law.

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment below. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF TREATMENT.**

I understand and acknowledge that the medical records may contain information regarding psychiatric disorders, Human Immune Deficiency Syndrome (AIDS), AIDS related conditions, alcohol and/or drug dependency/abuse.
This authorization for release of information is valid for sixty (60) days of signature, unless revoked by written notice to the providing institution, providing said notice is received prior to the release of information.

A copy of this Release shall have the same authority as the original

Patient: _____ Date: _____

Authorization of Legal Guardian: _____ Date: _____

Notice to online submitters: you will be asked to sign this form when you visit our office.