# ATHENA FAMILY MEDICINE

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Board Certified
Family Medicine


## PATIENT REGISTRATION

### PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Last name | First name | | M.I. | Previous name (if any) | |
| Mailing address | | Apt # | City | State | ZIP |
| Home phone | Cell phone | | Work phone | | |
| Date of birth | Sex: ☐ Male ☐ Female | | Marital status | Social Security # (optional) | |
| Appointment reminders by: ☐ Phone call ☐ Text message<br>If phone call, which number: ☐ Home ☐ Cell ☐ Work | | | Employer | | |
| Emergency contact name | Emergency contact phone | | Relationship to patient | | |
| Previous doctor (name and city) | | | Preferred pharmacy (name and location) | | |

### RESPONSIBLE PARTY (GUARANTOR) — if patient is under 18 or someone else pays

| | | | |
|---|---|---|---|
| Last name | First name | Date of birth | Phone |
| Address (if different from patient) | City / State / ZIP | | Relationship to patient |

### ADDITIONAL INFORMATION

| | |
|---|---|
| Email address | May we leave a message about your care and test results? ☐ Yes ☐ No |
| **Race** (check all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Prefer not to answer | |
| **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer | **Preferred language:** ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: _____ |
| **How did you hear about us?** ☐ Google search ☐ Friend or family ☐ Insurance directory ☐ Another doctor ☐ Online ad ☐ Other: _____ | |

### INSURANCE INFORMATION

| | |
|---|---|
| **PRIMARY** insurance company | **SECONDARY** insurance company |
| Policyholder name and date of birth | Policyholder name and date of birth |
| Patient relationship to policyholder | Patient relationship to policyholder |
| Member ID # Group # | Member ID # Group # |

**Financial responsibility and assignment of benefits.** I have read and agree to the Athena Family Medicine (AFM) Office Policy. I understand that I am responsible for payment regardless of insurance coverage. I assign to AFM all insurance benefits I am entitled to for services provided by AFM, not to exceed the amount I owe. I authorize AFM to release medical information to my insurance company or other payer as needed to process my claims. I understand that balances not paid within 90 days of notice may be sent to an outside collection agency.

**Medicare beneficiaries.** I request that payment of authorized Medicare benefits be made to AFM on my behalf. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

**Text and email.** If I choose text messages or email, I agree to receive appointment reminders and occasional requests for feedback about my visit. I understand these messages may not be encrypted and I accept that risk. Standard rates may apply. Reply STOP to opt out of texts.

I have received or reviewed Athena Family Medicine's Notice of Privacy Practices. Initials: _____

| Signature of patient or responsible party | Printed name | Date |
|---|---|---|
| _____ | _____ | _____ |