REGISTRATION INFORMATION

Today's date: ____/____/____

Patient Name: ___________________________________, ____ ______________
(Last) (First) (MI)

Birth date ____/____/____ Sex: M / F Marital Status: M S D W

Social Security #:__________________________Race: African American/Asian/Caucasian/Hispanic/Native American/Pacific Islander/Other
Preferred Language: ___________________________

Home Address: ____ Telephone : ( ) ____________________

____ Cell phone: ( ) ____________________

City________________________________, State:_________ Zip: _____________ E-mail: ______________________________

Occupation: ____ Bus. Phone ( ) _____________________

Employer Name and Address: ____ Your preferred method of contact:

____ _____________________________________

INSURANCE INFORMATION:

Insurance Company: __________________________________ Member #:____

Type: ☐ HMO ☐ PPO ☐ MEDICARE ☐ OTHER ☐ CASH/SELF-PAY

Subscriber's Name: ____________________________________, ____ ____________
(Last) (First) (MI)

Subscriber's SSN#____________________________________ Relationship to patient _________________________________

EMERGENCY INFORMATION:

Person to notify in case of an emergency:

Name ____Relationship _____________________Phone: ( ) ________________

Name ____Relationship_____________________ Phone: ( ) ________________

Nearest Relative: __________________________________Relationship_____________________ Phone: ( ) ________________

I hereby authorize North Coast Family Medical Group, Inc and any of its providers to release medical information as requested by my insurance carrier. I also authorize payment by my insurance carrier directly to NCFMG. Further, I understand that all charges incurred are my responsibility regardless of insurance coverage. I understand also that some services may not be covered by my insurance carrier.

____ _____________________________
Patient or Guardian signature and relationship Date

The physicians and physician's assistants in this practice participate in clinical research trials. These FDA-approved trials are designed to test newly developed or already on the market medications for patients with certain diseases. Many of our patients have benefited from such trials. Perhaps you may also. Please take a moment to answer the following:

I give permission to have information in my medical chart reviewed to determine if I may qualify for clinical research trials:

yes no Signature ____