Clifford
family medicine

Patient Registration Form

Patient Information

PATIENT INFORMATION

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact for Appointment Reminder Calls: ☐ Voice ☐ Text (Primary Health Medical Group is not liable for any wireless charges you may incur by choosing to receive text messages.)		If Voice, Please Select Preferred Number : ☐ Home ☐ Cell ☐ Work	
Date of Birth:	Sex: ☐ Male ☐ Female	Family Physician:	
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:		Relationship to Patient:	

Additional Information and Responsible Party

PERSON RESPONSIBLE FOR THE BILL **(ONLY IF DIFFERENT FROM PATIENT)**

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Spanish ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Arabic ☐ Russian ☐ Other	
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

How did you hear about us? ☐ TV ☐ Radio ☐ Online Ad ☐ Friend/Family Referral ☐ Walk In ☐ Other_____

I have read and agree to Clifford Family Medicine (CFM) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to CFM all money to which I am entitled for medical expenses related to the services performed from time to time by CFM, but not to exceed my indebtedness to CFM. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency.
MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefit be made to CFM. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

☐ **I have reviewed a copy of Clifford Family Medicine Privacy Notice.**
(Initials)

Signature of Responsible Party: **X** _____ **Date:**

Printed Name of Responsible Party: **X** _____ **Date:**