LEVITTOWN
Family Medicine

REGISTRATION FORM

Patient Information

Today's Date:

Patient Name:	☐ Male ☐ Female	Date or Birth:	Preferred Language:	Social Security:

Race: ☐ American Indian or Alaska native ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ White ☐ Black or African American ☐ Decline to Answer	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Street Address:	City, State, Zip Code:

Home Phone:	Cell Phone:	Email Address:

Employer Name:	Employer Address:	Employer Phone:

I authorize my physician's office to contact me using any of the above contact information _____
(please initial)

Emergency Contact Information

Emergency Contact:	Relationship:	Phone Number:

Insurance Information

Primary Insurance Name:	Policy Holder:	Relationship to Patient:	Date of Birth:

Insurance Address:	Subscriber Number:	Group Number:

Secondary Insurance Name:	Policy Holder:	Relationship	Date of Birth:

Insurance Address:	Subscriber Number:	Group Number:

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize and direct Levittown Family Medicine, having treated me, to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer and set over to Levittown Family Medicine sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents. I request that payment of authorized benefits be made on my behalf, and I understand I am responsible for charges not covered by policy or plan. (Medicare) I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the SS Administration and HCFA or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician furnishing the services or authorize such physician to submit a claim to Medicare for payment to me.

_____ _____

Signature of Patient or Authorized Guardian ***Date***