State of Franklin Healthcare Associates

# WALK-IN CLINIC

Patient Registration

(Please Print)

Patient Information

First Name ____ M.I. ____ Last Name ____

Birthdate ____ ☐ Male ☐ Female Age ____ Social Security Number ____

Address ____ City ____ State ____ Zip ____

(____) Home Telephone Number (____) Cell Telephone Number (____) Work Telephone Number

**Email Address:** ____ **Patient Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer's Name ____ Employer's Address ____ City/State ____ Employer's Telephone # ____

Primary Care Physician ____

***Referral Source - How did you hear about us?*** ☐ *Physician* ____ ☐ *Yellow Pages*

☐ *Newspaper* ☐ *SIGNS* ☐ *Family/Friends* ☐ *Other (please specify):* ____

Name of Spouse or Parent ____ Telephone # ____ Employer of Spouse or Parent ____

NAME OF FINANCIAL RESPONSIBLE PARTY AND ADDRESS ____ SSN# ____

In Case of Emergency Notify ____ Relationship ____ (____) Emergency Contact Telephone Number ____

Insurance Information

Primary Insurance ____ Identification Number ____ Group Number ____

INSURANCE SUBSCRIBER'S NAME: ____ RELATION TO PATIENT: ____

SUBSCRIBER'S DATE OF BIRTH: ____ ☐ Male ☐ Female SUBSCRIBER'S SOCIAL SECURITY #: ____

SUBSCRIBER'S EMPLOYER ____

Secondary Insurance ____ Identification Number ____ Group Number ____

INSURANCE SUBSCRIBER'S NAME: ____ RELATION TO PATIENT: ____

SUBSCRIBER'S DATE OF BIRTH: ____ ☐ Male ☐ Female SUBSCRIBER'S SOCIAL SECURITY #: ____

## Authorization

I hereby authorize State of Franklin Healthcare to release to the above companies (or their representatives) any information including the diagnosis and the records of any treatment or examination rendered to me. I authorize and request the above named companies to pay directly to State of Franklin Healthcare any benefits due for their medical or surgical services rendered to me. I permit a copy of these authorizations to be used in place of the original. I understand that I am responsible for payment of any and all charges incurred by me.

Date ____ Signature of Patient or Responsible Party ____