LILLINGTON FAMILY MEDICAL CENTER **PLEASE PRINT CLEARLY!**

PATIENT REGISTRATION

Name: ____

Male/Female: _____ SSN: ________________________ Date of Birth: ______________ Age: _________

Mailing Address: ____

City: _______________________________ State: ______________ Zip: _________________________

Physical address: ____

City: _______________________________ State: ______________ Zip: __________________________

Home Phone: _____________________ Cell: ______________________ Work: ____________________

E-mail address: ____

Best way to reach you: □Home □Cell □Work Can we leave a message? □Y □N

Marital Status: □Married □Single □Separated □Divorced □Widowed

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Other □Declined

Race: □Am Indian □Asian □Black □White □Other □Declined

Preferred Language (*if other than English*): ______________________

Please list any communication barriers *(deafness/blindness)*: _____________________________________

Emergency Contact/Relationship: ____________________________ Phone: _______________________

Guarantor of Bill/Relationship: ______________________________ Phone: _______________________

Insurance Carrier/Employer: ____

Policy Holder's Name: ______________________ DOB: _______________ SSN: ____________________

Please present proof of insurance card for copying. Payment is expected at time of service. Do not hesitate to speak to us now if this is a problem.

Authorization of Release of Information

Lillington Family Medical Center may disclose all or part of this patient's record to any insurance company or association and the Federal or State Government. Such information may be necessary for the completion of all clinic claims. I understand that the information to be released may include information pertaining to mental health or psychiatric related conditions and/or alcohol abuse. A copy shall be valid as the original.

Assignment of Benefits

I hereby authorize Lillington Family Medical Center benefits herein specified and otherwise payable to me for any services rendered by the clinic subsequent to this date and for such other charges as may be made by said clinic. I hereby agree to pay the same and also agree that in the event of medical coverage is sufficient to pay the indebtedness incurred and should there be any money over and above that is necessary to pay this registration, I agree that said clinic may apply coverage against any amount which is owed by myself, my spouse, or legal dependents of myself and my spouse at the time to Lillington Family Medical Center.

I certify the information given by me in applying under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related medical claims. I request that payment of Authorized Benefits be made on or in my behalf to Lillington Family Medical Center. A copy should be valid as the original.

I, the undersigned, certify that I have read the foregoing, and am the patient, or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

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Signature/Date Witness/Date