



Registration form for the patient including fields for Last, First, MI, Home Phone No., Work Phone No., Street Address, Cellular Phone No., E-mail Address, City, State, Zip Code, Employer, Social Security No., Marital Status (S, M, D, W), Date of Birth, Age, Sex (M, F), and Occupation.

Do you prefer one consolidated bill for all family members OR separate bills for each family member

If you prefer one bill for all family members OR someone other than the patient is responsible for payment of this account, please complete the following: Person Responsible for Account:

Registration form for the person responsible for the account, including fields for Last, First, MI, Home Phone No., Work Phone No., Street Address, Cellular Phone No., E-mail Address, City, State, Zip Code, Employer, Social Security No., Marital Status (S, M, D, W), Relationship, Date of Birth, Sex (M, F), and Hours Worked.

INSURANCE INFORMATION

Insurance information form with columns for PRIMARY INSURANCE and SECONDARY INSURANCE. Fields include Subscriber Name, Relationship, Subscriber Social Security No., Subscriber Date of Birth, Subscriber/Policy No., Group/Plan No., Subscriber Employer, Co-Payment Amount, and Effective Date of Ins.

Please Note: You are responsible to inform our office if pre-certification and/or referrals are required by your insurance company(s)

How were you referred to our office: _____

Emergency contact fields: In case of emergency, who should be notified (Relationship), Home Phone No., and Other: Work/Cellular.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits from any applicable insurance carrier be made on my behalf to Waukesha Family Practice Clinic, Ltd. for any services furnished me by that provider. I authorize medical information needed to determine these benefits or the benefits payable for the related services be released to the insurance company and its agents. I understand that even though I have some type of insurance coverage, I am responsible for the payment of services.

Signature and date lines for Patient/Parent/Responsible Party and Witness.

OTHER FAMILY MEMBERS AT YOUR ADDRESS

Table for listing other family members at the address with columns for Name, Birth Date, and Relationship.