Sarasota Family Medical

Registration Forms
(Please Print)

Patient Name:		Patient DOB(mm/dd/yyyy): / / Age:
Patient SSN:	Race:	Language:
Ethnicity: □Not Provided □Hispanic □Non Hispanic		Marital Status (Circle One): Single Mar Div Wid Sep Dom.Part
Primary Patient Street Address : (address, city, st, zip)		
Secondary Patient Street Address: (address, city, st, zip)		
Patient Phone Number(s): Home:	**Cell:**	**Work:**
Patient Email Address:		
Patient Employer:		☐ Please check here if visit is employment related.
Reason for your visit:		Chose clinic because/Referred to clinic by (please check one box): ↓↓↓

❑Family❑Insurance Plan❑Hospital❑Friend❑Close to home/work❑Yellow Pages❑ZocDoc❑Dr. _____ ❑Other_____

Pharmacy Name, Address, Phone Number(This may assist with calling in or electronically submitting medications): ↓↓↓↓↓↓↓

IN CASE OF EMERGENCY

Name of Friend or Relative: ↓↓↓↓↓↓	Relationship to patient: ↓↓↓↓↓↓↓	Best number to contact: ↓↓↓↓↓↓↓

Are we authorized to discuss any medical or financial issues with this person? ☐ Yes ☐ No

Are they authorized to make medical decisions? ☐ Yes ☐ No

Responsible Party Information (for minors)

Parent Name:	Parent SSN:	Parent DOB (mm/dd/yyyy):

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist.)

Is this patient covered by insurance?	☐ Yes	☐ No	Insurance Carrier:
Subscriber's name:	Subscriber's S.S#:		Subscriber's Birth date:

Privacy Policy Acknowledgement

With my consent, Sarasota Family Medical Clinic may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations, as well as to comply with a subpoena or worker's compensation matter. I further authorize Sarasota Family Medical Clinic to access my medication history through our electronic prescription service.

I have the right to review Sarasota Family Medical Clinic's Notice of Privacy Practices, prior to signing this consent. I may revoke my consent in writing except to the extent that the practice has already made disclosures upon my prior consent.

In addition, I authorize Sarasota Family Medical Clinic to leave a message regarding appointment reminders with whoever answers my cell phone, home phone or on my answering machine.

PLEASE PROVIDE YOUR INSURANCE CARD AND DRIVERS LICENSE SO WE CAN MAKE A COPY FOR YOUR FILE.

ASSIGNMENT and RELEASE: I certify that I, and/or my dependent(s) have insurance coverage with the above insurance company(ies) and assign directly to Sarasota Family Medical Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature of all insurance submissions.

The above named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize Sarasota Family Medical Clinic to download my medication history and Rx benefits into my account from a Rx clearinghouse.

Patient/Parent/Guardian Signature:	Date:
Parent/Guardian Name(printed):	Relationship:

I have reviewed and certify the above information is true to the best of my knowledge.

Sarasota Family Medical

Patient Consent for Receipt and Transmittal of Protected Health Information

DO WE HAVE PERMISSION TO:	(Please Circle One)	
1. Mail notices to your home address:	YES	NO
2. Leave the following information on your HOME answering machine/voice mail:		
a. Appointment information	YES	NO
b. Billing information	YES	NO
c. Medical information	YES	NO
3. Leave the following information on your WORK answering machine/voice mail:		
a. Appointment information	YES	NO
b. Billing information	YES	NO
c. Medical information	YES	NO
4. I give permission to share appointment and billing information with the person listed below:		
a. Name:_____		
5. I give permission to share medical information with the person listed below:		
a. Name:_____		

Patient Name:_____	Date of Birth: ____/____/____
Patient Signature:_____	Date: ____/____/____
Guardian Signature: (If under 18 years old)_____	Date: ____/____/____
Guardian Name (Printed):_____	