Thompsonhealth
Family Practice
Health care for the whole family

REGISTRATION FORM

NAME: ____ DATE OF BIRTH: __________________
LAST FIRST MI

ADDRESS: ____
STREET/PO BOX CITY STATE ZIP CODE

GENDER: ___ Male ___ Female MARITAL STATUS: ___ Single ___Married ___ Divorced/Separated

SOCIAL SECURITY NUMBER: _______________________HOME PHONE #:______________________

CELL NUMBER: _______________________________PAGER: __________________________________

EMPLOYER: ____

ADDRESS: ____

WORK PHONE NUMBER: ____

PERSON TO NOTIFY IN CASE OF EMERGENCY:____

ADDRESS:____RELATIONSHIP:_________________

PHONE #:_____________________ WORK PHONE #:___________________CELL #:_________________

INSURANCE INFORMATION:

GUARANTOR: ____________________________________RELATIONSHIP: _______________________

GUARANTOR'S S.S.NUMBER: ____

PRIMARY INSURANCE: ____

POLICY NUMBER: ____

POLICY CARRIER: ____

SECONDARY INSURANCE: ____

POLICY NUMBER: ____

POLICY CARRIER: ____

HOW DID YOU HEAR ABOUT US? ___WEB SITE ____ MOVIE THEATRE
____NEWSPAPER ___WORD OF MOUTH ____ OTHER ___________

IT IS MY UNDERSTANDING THAT F.F.THOMPSON FAMILY PRACTICE WILL BILL MY INSURANCE COMPANY ON MY BEHALF FOR COVERAGE OF MY VISIT. I ALSO UNDERSTAND THAT IF MY POLICY HAS A DEDUCTIBLE, COPAYMENT, OR DOES NOT COVER CERTAIN PROCEDURES, I AM RESPONSIBLE FOR THAT BILL. IN THE EVENT THAT MY CHECK IS RETURNED DUE TO INSUFFICIENT FUNDS, I REALIZE THAT I AM RESPONSIBLE FOR THE BANK SURCHARGE OF $10.00 OR GREATER IF DICTATED BY THE BANK.

SIGNATURE: ____ DATE: __________________________