Michigan Family Physicians
ADULT REGISTRATION FORM

Date: _____ Home Phone: _____

Name: _____ Cell Phone: _____

Address: _____ Birth Date: _____ Sex: M F

City: _____ State: ____ Zip Code: _____ Marital Statue: S M D W

Social Security #: _____ Email Address: _____

Patient's Employer: _____ Work Phone #: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Spouse's Name: _____ Spouse's Birth date: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Spouse's Social Security #: _____ Referred By: _____

Name of person to contact in case of Emergency: _____Phone #: _____

Please give the front desk your Insurance card(s) and photo ID to copy for your permanent records. Thank You.

Is Insurance coverage through: ___ Your Work ___ Spouse's Work ___ Parent ___Other

For Staff Use

Staff will copy front and back of Insurance card(s) and Driver's License

I authorize the release of medical and other information to my insurance company for review of my coverage and/or processing of claims for services rendered to me.

I permit a copy of the authorization to be used in place of the original.

I understand that I am responsible for any charges incurred that are not covered by my insurance company.

_____ _____

Signature of Patient/ Guardian **Date**