

SPRINGFIELD BURKE FAMILY PRACTICE
PATIENT REGISTRATION – PLEASE PRINT LEGIBLY

PATIENT INFORMATION		Sex M F	Birth Date ____/____/____	Marital Status Single [] Married [] Widowed [] Divorced []
First Name _____				
Last Name _____				
E-Mail Address:			Home Phone:	Patients Social Security#:
Street Address			City State	Zip Code
RESPONSIBLE PARTY NAME IF PATIENT IS UNDER 18		Responsible Party's Birthdate ____/____/____		Responsible Party's Social Security #
Name of Employer Address		Business Phone		Cell Phone
Person to contact in case of emergency:		Relationship to patient		Phone

PRIMARY INSURANCE INFORMATION				
Insurance Company Name		Address		Subscriber SS#:
Subscriber Name		Subscriber birth date	Policy #	Group #
Relationship to patient:				

SECONDARY INSURANCE INFORMATION				
Insurance Company Name		Address		Subscriber SS#:
Subscriber Name		Subscriber birth date	Policy #	Group #
Relationship to patient:				

Authorization for Assignment of Benefits/Information Release:

I, (patient/guardian) _____, herby authorize Springfield Burke Family Practice, to apply for benefits on my behalf for the services I have received, from my Insurance Carrier listed above. I authorize payment of medical benefits to be made directly to Springfield Burke Family Practice for any services furnished to me by the physician or practitioner. I understand that I must select Springfield Burke Family Practice or Dr. Tucker as my PCP and if I have not done so I will be responsible for all services provided. I also understand that my Insurance Carrier may not cover all services provided and I may be responsible for any services that are non-covered. I certify that the Insurance information that I have provided is accurate and understand that if it is not accurate I will be financially be responsible for the services provided. I understand that I will be responsible for any fees relating to my account being sent to an outside collection agency, attorney, in addition to any court costs in an attempt to collect for the services provided. I understand that I am responsible for all administration fees assessed on my account, i.e. referral fee, prescription fee, co-pay not paid fee, returned check fees, no-show and late cancellation fees, etc. I authorize you to release to my insurance company or their agent information concerning health care, advice, medical records, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I permit a copy of this authorization to be used in place of an original.

 Patient, Parent or Guardian Signature (if child is under 18 years old) _____
Date

By Initialing below I am acknowledging that the above information is accurate and I agree to the terms listed above.
 Initial and date below

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____