NEW PATIENT REGISTRATION

____ ______________ ____________

First Name, Middle Initial, Last Name *Date of Birth* *Gender*

____ ________________________________

Home Address *Mailing Address if different*

____________________ ___________________ _______________________________

Primary Phone Number *Cell Phone Number* *Email Address*

______________________________ ___________________________ ______________

Employer or School Information *Emergency Contact or Next of Kin* *Contact number*

________________________ ____________________ ______________ __________

Primary Insurance Carrier *Plan Type (HMO, PPO etc.)* *Member ID #* *Group ID #*

________________________ _________________ ________ __________________

Guarantor Name *Date of Birth* *Effective Date* *PCP Last Name*

Notice of Private Practices and Financial Policy Available for review upon request.

__________ I acknowledge receipt of the financial policy and notice of private practice policies.
Initial Here

__________ I authorize my insurance company to pay on my behalf and make payment of benefits for
Initial Here services rendered at Wakefield Family Medicine, PLLC.

__________ I authorize Wakefield Family Medicine, PLLC to release medical information to other
Initial Here providers including specialists, hospitals, other care providers, insurance carrier for payment or review purposes.

__________ I acknowledge that any uncovered medical services are the patient's sole responsibility and
Initial Here any overdue payments are subject to collection.

__________ I express consent to receive automated text and voice messages at the phone number(s) listed
Initial Here above.

Patient, Parent or Guardian Consent and Signatures

__________________________ ________________________________ _____________

Patient Printed Name *Patient Signature* *Date Signed*