SW Durham Family Medicine, PLLC

A Healthy Life

Patient Registration

3612 Shannon Road, Suite 105
Durham, NC 27707
phone (919) 419-0242
fax (919) 401-4172

Today's Date _____

Patient Information

Last Name _____ Social Security # _____

Maiden or Nickname _____ Birth Date _____

First Name _____ Middle Name _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Home Phone Number _____ OK to leave message? ◯ Yes ◯ No

Work Phone Number _____ OK to leave message? ◯ Yes ◯ No

Email Address _____ OK to leave message? ◯ Yes ◯ No

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed Other _____

Patient's Employer Information

Patient's Employer _____ ◯ Full-time ◯ Part-time

Employer's Address _____ Suite _____

City _____ State _____ Zip _____

If Student, School Name _____ ◯ Full-time ◯ Part-time

Insurance Information — *Primary, Secondary, Other*

Do you have health insurance? ◯ Yes • **Please give Insurance Card(s) to the Receptionist** ◯ No

Primary Insurance Company Name _____

Please indicate the policyholder for the Primary Insurance ◯ Self ◯ Parent ◯ Spouse Other _____

Secondary Insurance Company Name _____

Please indicate the policyholder for the Secondary Insurance ◯ Self ◯ Parent ◯ Spouse Other _____

Spouse or Parent's Information — *If patient is covered by spouse or parent*

Spouse / Parent's Name _____ Spouse / Parent's Birth Date _____

Spouse / Parent's SSN _____ Employer's Phone _____

Spouse / Parent's Employer's Address _____

City _____ State _____ Zip _____

Emergency Information

In case of emergency, please list the nearest living relative / friend (other than your spouse / parent) we may contact:

Name _____

Phone _____

Relationship _____

Preferred Pharmacy

Unless otherwise specified, we will fax prescriptions to the following pharmacy:

Name _____

Location _____

Phone _____

Fax _____

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Authorization for Payment

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payment of medical benefits to Southwest Durham Family Medicine, PLLC, its successors and assigns, or any individual it may designate for services provided.

I further agree to pay all costs of collection, including attorney's fees, associated with collection of any amount due to services rendered and performed. I will pay interest at the prevailing annual rate for all amounts 30 days past due. I understand that I am financially responsible to the Southwest Durham Family Medicine, PLLC, its successors and assigns and any individual it may designate for any balance not covered by insurance.

Signature of Patient or Parent of Minor _____ Date _____

Authorization for Medicare — *Medicare patients only*

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Southwest Durham Family Medicine, PLLC, for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Parent of Minor _____ Date _____

Authorization for Release of Health Information

I authorize Southwest Durham Family Medicine, PLLC, to release all medical information to my referring physician, my primary care physician, and any other physician and/or provider organization, including hospitals/clinics, laboratories, and pharmacies, requiring such information in the course of my care.

I agree that these provisions will remain in effect until I provide written revocation to Southwest Durham Family Medicine, PLLC.

Signature of Patient or Parent of Minor _____ Date _____

How did you hear of us?

◯ Current Patient • Name _____ ◯ Physician Referral • Name _____

◯ Health Plan/Insurance Directory

Advertising—*please specify*

◯ Yellow Pages ◯ ValPak ◯ Internet ◯ Newspaper Other _____