Leawood Family Care, P.A.
NEW PATIENT REGISTRATION FORM

Patient Name: ____
Address: ____
____
____

Social Sec #: ________________________
Sex: ___Male ___Female Birth Date: ____________ Age:__________
Marital Status: __Single __Married __Divorced __Widowed
How did you learn about us?: __Friend __Relative __Yellow Pages
Physician:__________________________

Home Phone: ____________________ Work Phone: _____________
Employer :____ Occupation: ____________________________

Emergency Contact:____ Relationship: ________________
Home Phone: (_____) __________________________ Work Phone: (_____) ___________________________

Who is financially responsible for payment for these services?
__Self __Spouse __Parent/Guardian __Workers Comp Other: ____________________________________

Responsible Party or Bill To Information:
Full Name: ____ Relationship:_______________ _
Address: ____
City:____ State: _______________ Zip:______________
Home Phone: (______) __________________________ Work Phone: (______) __________________________
Birth Date: ________________ Age: ________ Social Sec. #:________________________________
Employer: ____

Insurance Information: Please have your insurance card(s) handy so that we may scan the information into your record.
If your primary insurance is an HMO, please, provide the name of your primary care physician.

Dr.: ____ Phone: (_______) _________________________

Assignment Of Benefits and Authorization To Release Medical Information

I request that payment of authorized benefits Medicare, Medicaid, and/or any Insurance Carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to me my that physician/supplier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services.

Signature:____ Date:_________________________