EUNOIA
FAMILY RESOURCE CENTER, PA

# REGISTRATION INFORMATION

| Account # *For Internal Use* | **DATE:** |
|---|---|

## PATIENT INFORMATION

| LAST NAME | FIRST NAME | MI | BIRTHDATE | SPOUSE'S NAME | | |
|---|---|---|---|---|---|---|
| HOME ADDRESS | CITY | | STATE | ZIP | SEX: ❑ MALE ❑ FEMALE | |
| MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ SEPARATED ❑ WIDOWED | HOME PHONE | | OTHER PHONE | | | |
| SOCIAL SECURITY NUMBER | **PLEASE STAR WHICH PHONE NUMBER YOU WOULD PREFER WE USE TO CONTACT YOU. | | | | | |
| EMPLOYER OR SCHOOL NAME IF STUDENT: | HOW DID YOU FIND US? | | | | | |

## EMERGENCY INFORMATION

| NEXT-OF-KIN (For Emergency – Other than Spouse) | | | | RELATIONSHIP |
|---|---|---|---|---|
| NEXT-OF-KIN ADDRESS | CITY | STATE | ZIP | NEXT-OF-KIN PHONE |

## RESPONSIBLE PARTY INFORMATION (If the same as patient, write "Same.")

| RESPONSIBLE PARTY NAME LAST | FIRST | MI | | RESPONSIBLE PARTY HOME PHONE |
|---|---|---|---|---|
| RESPONSIBLE PARTY ADDRESS | CITY | STATE | ZIP | RESPONSIBLE PARTY SOCIAL SECURITY # |
| RESPONSIBLE PARTY DATE OF BIRTH | | | | RELATIONSHIP TO RESPONSIBLE PARTY ❑ SELF ❑ SPOUSE ❑ SON ❑ DAUGHTER |

## INSURANCE INFORMATION

***Please note that we will need a copy of all of the patient's insurance cards.**

| PRIMARY INSURANCE | CARDHOLDER | | | DATE OF BIRTH |
|---|---|---|---|---|
| GROUP NUMBER | IDENTIFICATION NUMBER | | | |
| INSURANCE ADDRESS | CITY | STATE | ZIP | PHONE |
| SECONDARY INSURANCE | CARDHOLDER | | | DATE OF BIRTH |
| GROUP NUMBER | IDENTIFICATION NUMBER | | | |
| INSURANCE ADDRESS | CITY | STATE | ZIP | PHONE |

## ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment to Eunoia Family Resource Center, PA of any medical benefits otherwise payable to me for the services provided at Eunoia Family Resource Center, PA.

X

Patient Signature or Signature of Guardian or Parent Date

RECORDS RELEASE

I hereby authorize Eunoia Family Resource Center, PA to release my records to my insurance company for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

X

Patient Signature or Signature of Guardian or Parent Date