David Barney Family Medicine
6690 Crossings Dr. SE suite C, Grand Rapids, MI 49508
p: (616) 600-1885
f: (616) 600-2782

PATIENT REGISTRATION FORM

Name: _____ Date of Birth: _____

Sex: • Male • Female Social Security #: _____

Parent / Guardian:_____ Soc. Sec. #:_____

Home Address:

_____

City / State / Zip:

Phone #: • Home _____ • Work _____ • Mobile _____
(Please check your preferred primary phone number to be reached at)

E-mail Address: _____

Employer:_____

Marital Status: • Single • Married • Widowed • Divorced • Separated

Spouse's name: _____

Referred to David Barney Family Medicine by: _____

Emergency Contact: _____ Relationship: _____

Phone #: Home _____

Work _____ Mobile _____

Permission to treat & release records: I authorize David Barney Family Medicine to provide medical treatment to myself of the above-named patient, for whom I am legally authorized to obtain medical treatment. I further authorize David Barney Family Medicine to furnish medical information, including diagnoses and copies of my medical record, to my insurance company in order to determine liability for payment and to obtain reimbursement on my behalf. I assign benefits payable, to which I am entitled, directly to David Barney Family Medicine. I understand that during the course of my treatment by David Barney Family Medicine, the services of a specialist, hospital, laboratory, or other medical provider may be required. By signing this authorization, I give permission to David Barney Family Medicine to release any part of my medical record that would be pertinent to treatment and/or evaluation by such a medical provider. In addition, I give permission to David Barney Family Medicine to release any demographic or insurance information (including my Social Security Number if required for billing or payment purposes) to such a medical provider. I have read and understand the above information. In addition, I agree that a copy of this authorization shall be valid as the original. This authorization may be revoked at any time by written request.

I also understand that this office may leave appointment reminders, lab and/or x-ray results, and billing questions on the phone numbers listed on this form or in the computer system.

_____

Signature of Patient (or Parent/Guardian) Date