INSURANCE INFORMATION MUST BE PRESENTED AT EVERY VISIT ALONG WITH YOUR PHOTO IDENTIFICATION

Patient Registration Form

PLEASE PRINT CLEARLY

Patients full legal name:	Date of Birth: / /	Sex: ☐ M ☐ F	Age:
Mailing Address:	City:	State/Zip:	

Home: *Check to make Primary #* ( )	Mobile: *Check to make Primary #* ( )	Work: *Check to make Primary #* ( )
Email:		
Please enroll me in the Patient Portal ☐ Yes, *my email is listed above* ☐ Not at this time	Marital status: ☐ Single ☐ Married Other: ☐ Divorced ☐ Widow	Ethnicity: ☐ Hispanic Latino ☐ Non-Hispanic Latino ☐ Decline to answer

EMERGENCY CONTACT

Name:	Relation to patient:	Contact number (s):

RESPONSIBLE PARTY

Patient social security number: / /	Guarantor's contact number:
If the patient is a minor (under 18) Guarantor's full legal name:	
Guarantor's mailing address, if different than patient:	
If the patient is a senior with a legal Power of Attorney (POA) or a minor, please give POA/guardian/parents name and relation to patient:	I have a Advance Directive .... ☐ Yes ☐ No *If yes, please provide a copy to the office so we may make it part of your medical record.*

PHARMACY INFORMATION

Pharmacy Name and Location:	Pharmacy number:

RX history Consent: I herby authorize Aspen Family Medicine & Geriatrics to obtain my previous prescription /medication history through external sources ________ (initials please)

OTHER INFORMATION

May we notify you via email/web portal of your test/lab results?....................................... ☐ Yes ☐ No

May we leave test results on your answering machine/voicemail?.................................... ☐ Yes ☐ No

May we inform you of medical updates and promotions for Aspen and its affiliates?......... ☐ Yes ☐ No

May we disclose your health information to individuals you designate?............................ ☐ Yes ☐ No

**if yes, please obtain a release of information form from front desk*

The above information is to complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits otherwise payable to me to Aspen Family Medicine & Geriatrics. I understand that I am financially responsible for charges for medical services rendered regardless of insurance coverage. I also understand that I am responsible for any office visit co-payments due at time of service and/or deductibles, additional fees for form processing, returning checks, copying of medical records and missed appointments that may apply. If this account is assigned to an attorney for collection and/or suit, a copy of the signature is valid as the original.

Signature ____ **Date**____________________

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