Welcome to AAC Family Wellness Center

Patient Registration Form

Patient Information *(Please Print)* Date:_________________

Name:____
(Last) (Maiden) (First) (Middle)

Address:____

City:_____________________________ State:____________________________ Zip:_____________

Who can we thank for your referral?____

Email address:_______________________________________

Sex: Male____ Female_____ Date of Birth:______________________ Age:_____________

Patient's Employer:_________________________ Address:_______________________________

Telephone: Home:___________ Cell:____________ Work:___________ Ext:_______

Social Security # _______-_______-_______ Marital Status:______S_______M
(S.S. # Required)

Insurance Information

Name of Insurance: First ins.______________________ Second ins._______________

First Primary ID# ______________________ Group ________ Co pay _______

Secondary ID # ______________________ Group ________ Co pay _______

Person responsible for billing: (Whomever insurance is carried by)

Name:____
(Last) (Maiden) (First) (Middle)

Patients relationship to holder of Insurance:_____________________________________

Date of Birth of Insurance Holder:___________ Social Security #_____-_____-_____

Address:____

Employer of Insurance Holder:__________________________Telephone ____________________

I, authorize any holder of medical or other information about me to be released to insurance carrier(s) needed to process this or a related claims. I permit a copy of this authorization to be used in place of the original. Also, I request payments of medical insurance benefits be made to me or the party who accepts assignments as my medical provider. ***In the event my insurance carrier(s) do not pay I agree to be financially responsible for any depts incurred***

Patient's Signature: ___________________________________ Date:_________________