FamilyMedix New Patient Registration Form

Last Name:	**First /Middle name:**
Date of Birth:	**Female** ☐ **Male** ☐
Insurance name and ID number:	
Home Address:	
Email Address:	
Mobile Phone:	**Other Phone:**
Pharmacy Name/Address/phone:	
Emergency Contact name:	**Emergency Contact phone:**
How did you hear about us? Please indicate a name of physician, friend, or family: _____	

ACKNOWLEDGEMENT AND AUTHORIZATION- Please read and sign

- **IMPORTANT:** Please note that based on your contract with your insurance company, you may have deductible, co-insurance or out of pocket amount so your copay may not cover your entire service fee. By signing this form, you acknowledge that you will be responsible for your service fee if insurance denies your service claims.
- I authorize FamilyMedix, PLLC to release medical information required to process my claim.
- I hereby assign my insurance benefits to be paid directly to the healthcare provider.
- I authorize FamilyMedix, PLLC to obtain/have access to my medication history.
- I authorize my provider's office to contact me by mobile phone.

First and last name: _____ **Signature *of Patient or Legal Guardian/Date*** _____