Highlands Family Medicine

A Home for your Health in the Highlands

1250 Bardstown Road, Louisville, Kentucky 40204 502/456-7047

NEW PATIENT REGISTRATION

First | *Middle* | *Last*

Date of Birth | *Marital Status* | *Social Security #*

☐ Male ☐ Female

Home Street Address

City | *State* | *Zip*

Home Phone | *Pager* | *Cell*

Fax | *Email*

Employer | *Occupation*

Work Address

City | *State* | *Zip*

Work Phone

ACCESS TO INFORMATION: *I authorize the following to receive medical information on my behalf*

Name | *Relationship to Patient*

EMERGENCY CONTACT

Name | *Relationship to Patient* | *Phone*

PARTY RESPONSIBLE FOR BALANCE

Name | *Relationship to Patient* | *Phone*

Address

City | *State* | *Zip*

AUTHORIZATION AND ASSIGNMENT TO RELEASE INFORMATION TO INSURANCE CARRIER

I certify that I (or my dependent) have insurance coverage with the above payor(s) and assign directly to Highlands Family Medicine all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize use of my signature on all insurance submissions.

Signature | *Date*