

DATE _____	PATIENT REGISTRATION	PATIENT NUMBER _____
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Patient Information

SOCIAL SECURITY # _____	HOME ADDRESS _____
FIRST NAME _____ MIDDLE _____	CITY _____ STATE _____ ZIP _____
LAST NAME _____	EMAIL _____
SEX _____ DATE OF BIRTH ____/____/____	HOME PHONE (____) _____
MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	WORK PHONE (____) _____
<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	CELL (____) _____
(CHECK ONE) <input type="checkbox"/> EMPLOYED <input type="checkbox"/> RETIRED <input type="checkbox"/> FULL TIME STUDENT	PRIMARY PHYSICIAN _____
<input type="checkbox"/> OTHER _____	EMPLOYER _____

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

COMMERCIAL MEDICARE WORKER'S COMPENSATION OTHER _____

EMERGENCY CONTACT

NAME _____	PHONE (____) _____
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SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # _____	SEX _____	DATE OF BIRTH ____/____/____
RELATIONSHIP _____	DAYTIME PHONE (____) _____	
FIRST NAME _____ MIDDLE _____	EMPLOYER _____	
LAST NAME _____	ADDRESS _____	
ADDRESS _____	CITY _____	STATE _____ ZIP _____
CITY _____	STATE _____	ZIP _____

Please read and sign the four statements below. Providing your signature acknowledges that you have read, understood, and are agreeable.

If you have any questions regarding any of these statements please ask the receptionist before providing your signature. Thank you.

<p>The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I also authorize FastER Care or my insurance company to release any information required to process my claims. I consent to treatment by the physicians of FastER Care and to appropriate tests for the presence of infection, such as, but not limited to Hepatitis B Virus, Hepatitis C Virus, or HIV if deemed necessary and authorize the withdrawal of blood or other body fluids for this purpose.</p>	<p style="text-align: center;">Signature (patient or parent if patient is a minor) Date</p>
<p>RECEIPT OF NOTICE OF PRIVACY PRACTICES: I verify that I have received a copy of FastER Care's notice of privacy practices.</p>	<p style="text-align: center;">Signature (patient or parent if patient is a minor) Date</p>
<p>I am aware that ALL radiographic studies including but not limited to x-rays, cat scans and ultra sounds will be read by a radiologist who will require a separate payment. All laboratory procedures not executed at FastER Care will also require a separate payment. The patient will be responsible for these charges, not FastER Care.</p>	<p style="text-align: center;">Signature (patient or parent if patient is a minor) Date</p>
<p>Payment for the patient portion will be collected at the time of service; including co-pays, coinsurance, and any portions of your unpaid deductible. Collection accounts will receive a 28% charge on all unpaid balances. Bounced checks will receive a \$30.00 charge.</p>	<p style="text-align: center;">Signature (patient or parent if patient is a minor) Date</p>

