FRANKLIN-WILLIAMSON BI-COUNTY HEALTH DEPARTMENT
Patient Registration Form

PATIENT INFORMATION

Patient Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone Number: Cell: ______________________ Consent to Call Yes ☐ No ☐

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender: ☐ Male ☐ Female

DATE OF BIRTH: ____/____/____ Email Address: ______________________ ☐ Opt out of Email Communications

Primary Care Physician: ______________________________

RESPONSIBLE PARTY INFORMATION (Information Used for Patient Billing Statements)

☐ Check Here if Same As Patient

Name of Responsible Party: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone Number: Cell: ______________________ DATE OF BIRTH: ______/_______/________

Relationship to Patient: ______________________________

INSURANCE INFORMATION:

PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE
Ins. Co Name	Ins. Co Name
Policy Holder Name Date of Birth	Policy Holder Name Date of Birth
Policy Holder Address	Policy Holder Address
Patient Relationship to Policy Holder	Patient Relationship to Policy Holder
Policy ID	Policy ID

PAYMENT INFORMATION: INITIAL

________ Bill my insurance company. I authorize my insurance company to pay benefits directly to FWBCHD.

FINANCIAL RESPONSIBILITY: ___________ INITIAL

I understand that I am financially responsible for all charges for services rendered by Franklin-Williamson Bi-County Health Department. I understand all co-pays and deductibles due are my responsibility. I further understand that if my insurance company has not paid within 90 days, I am responsible for the full amount due Franklin-Williamson Bi-County Health Department. If it becomes necessary for the account to be transferred to a collection agency for collection, I agree to pay all costs of collection including attorney fees.

I certify:

1. That I have read or have had this consent read to me;
2. That I was given an opportunity to ask questions;
3. That all questions were answered to my satisfaction; and,
4. That I understand this consent and accept its terms and conditions

______________________________ ______________________

Signature of Patient (or Parent/Legal Guardian) Date

______________________________ ______________________

Printed Name of Patient (or Parent/Legal Guardian) Relationship to Patient

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Witness

7/2018