HEALTHY OUTCOMES

FAMILY HEALTH OF GEORGETOWN
NEW PATIENT REGISTRATION
PLEASE PRINT

First Name ____________ **Last Name** ____________

Address ____________

City ____________ **State** ____________ **Zip** ____________

Home Phone ____________ **Work Phone** ____________ **Cell Phone** ____________

Birth Date ____________ **SS#** ____________ **Sex** ____________ **Marital Status** ____________

Race ____________ **Email Address** ____________

Employer ____________

Guarantor/Spouse/Parent ____________ **Relationship** ____________

Address ____________ **Phone** ____________

Do you have Insurance? ____________

Name of Insurance ____________

Subscriber Name ____________ **D.O.B.** ____________ **SS#** ____________

PATIENT RELEASE: I, THE UNDERSIGNED, HAVE Medicare/Insurance coverage as noted above an assign directly to LEWES SURGICAL AND MEDICAL ASSOCIATES, P.A., all medical benefits. I authorize release of medical information to insurance companies and other physicians as is necessary for filing medical claims or for consultants. I authorize payment of medical claims to the provider. I understand that I am financially responsible for all charges not paid by insurance. I authorize the use of this signature on all my insurance submissions. **I understand that if I have no insurance, I am liable for this account.**

Signature ____________ Date ____________
Patient, Parent, or Guarantor

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