Patient Registration Form

Patient Information

Patient Name: _____ Sex: _____ M_____ F
Social Security#: _____ Date of Birth: _____
Address: _____ Apt: _____
City, State: _____ Zip Code: _____
Home Telephone (Primary):_____ Work: _____ Cell: _____
Email Address:_____
Employer: _____ Occupation: _____
Marital Status: _____ Married_____ Single_____ Divorced_____ Widowed_____ Separated
Spouse's Name: _____
Spouse's Employer_____ Employer Phone #:_____
If patient is a minor,
Guardian Name: _____ Relationship: _____
Date of Birth: _____ Social Security #:_____
Address: _____ Contact #:_____
_____ Email: _____
Who referred you to our office?_____
Please list any other friends and family that come to our office.

What Pharmacy do you use? _____ Address: _____
Phone Number: _____ Fax Number: _____

Emergency Contact: (person not living in your household)
Name: _____ Relationship:_____
Address: _____ Apt: _____
City, State: _____ Zip Code: _____
Home Phone: _____ Cell: _____ Work: _____

RELEASE (Please Read Carefully)

I authorize the release of any medical information necessary to process this claim and any other future claims. I also authorize payment of medical benefits to James River Family Practice, LLC. In the event that my insurance company does not cover services, I will be responsible for any unpaid balances, subject to any interest or late fees, or collection fees of 33% and/or litigation fees. JRFP, LLC also reserves the right to access your prescription monitoring program report.

Signature: _____ Date: _____
Relationship to Patient: _____