KOCH FAMILY MEDICINE PATIENT REGISTRATION
PLEASE PRINT

Date: _____

Name: _____ Date of Birth: _____ Sex: _____

Address: _____ City: _____ State: _____ ZIP: _____

SS#: _____ Preferred Phone: _____ Alternate Phone: _____

Email: _____ Ethnicity: _____

Marital Status: _____ Spouse Name: _____ Spouse Birth Date: _____

Please circle your preferred method of notification for upcoming appointments:

- Email Confirmation
- Text Message Confirmation
- Voicemail Confirmation

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insurance: _____

ID#: _____ Group#: _____

Policy Holder Name: _____

Policy Holder Birth Date: _____

SECONDARY INSURANCE

Name of Insurance: _____

ID#: _____ Group#: _____

Policy Holder Name: _____

Policy Holder Birth Date: _____

If billing address is different from patient's address, please provide billing address below.

Name: _____ Birth Date: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ ZIP: _____

NEXT OF KIN CONTACT

Name: _____ Birth Date: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone Number: _____

I hereby authorize Koch Family Medicine to release any information regarding services rendered and allow a photocopy of my signature to be used to file insurance: I authorize and direct my primary insurer and my secondary insurer to issue payment checks directly to Koch Family Medicine for benefits due me for the services rendered – regardless of my insurance benefits, if any. I understand I am financially responsible for the fees for services rendered.

Patient or Parent/Guardian Signature: _____ Date: _____