Leawood Family Care, P.A.
NEW PATIENT REGISTRATION FORM

Patient Name: _____
Address: _____
_____
_____

Social Sec #: _____
Sex: ___Male ___Female Birth Date: _____ Age:_____
Marital Status: __Single __Married __Divorced __Widowed **How did you learn about us?:** __Friend __Relative __Yellow Pages
Physician:_____

Home Phone: _____ Work Phone: _____
Employer :_____ Occupation: _____

Emergency Contact:_____ Relationship: _____
Home Phone: (_____) _____ Work Phone: (_____) _____

Who is financially responsible for payment for these services?
__Self __Spouse __Parent/Guardian __Workers Comp Other: _____

Responsible Party or Bill To Information:
Full Name: _____ Relationship:_____ _
Address: _____
City:_____ State: _____ Zip:_____
Home Phone: (_____) _____ Work Phone: (_____) _____
Birth Date: _____ Age: _____ Social Sec. #:_____
Employer: _____

Insurance Information: Please have your insurance card(s) handy so that we may scan the information into your record.
If your primary insurance is an HMO, please, provide the name of your primary care physician.

Dr.: _____ Phone: (_____) _____

Assignment Of Benefits and Authorization To Release Medical Information

I request that payment of authorized benefits Medicare, Medicaid, and/or any Insurance Carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to me my that physician/supplier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services.

Signature:_____ Date:_____