# Family registration

Please print

**Office use only**
**Acct. #** ________________

**Responsible party**

Last name ______________________________ Home phone ______________
First name ____________________ M.I. ______ Work phone ______________
Street address __________________________ Date of birth ______________
City ____________________ State ______ Social Security No. ______________
ZIP Code ____________________ Sex (M/F) ______ Doctor ______________
Employer ______________________________
Address ______________________________
City ______________________________
State ____________________ ZIP Code ______

**Spouse's name**

Employer ______________________________ Date of birth ______________
Address ______________________________ Social Security No. ______________
City ______________________________ Work phone ______________
State ____________________ ZIP Code ______

**Dependent children's names (with middle initial)**

1. ______________________________ DOB ______________
2. ______________________________ DOB ______________
3. ______________________________ DOB ______________
4. ______________________________ DOB ______________

**Medical insurance**

Name of carrier __________________________ Policy # ______________
Address ______________________________ ID # or SS # ______________
City ____________________ State ______ Medicare # ______________
ZIP Code ______________ Phone ______________
Insured party's name ______________________

If more than once insurance, please list: ______________________________

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**We accept:** ☐ Cash ☐ Check ☐ Visa ☐ MasterCard ☐ Discover

# Assignment of benefits

Statement to permit payment of Medicare benefits to provider, physicians and patients

## Medicare patients

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in Fox Valley Family Physicians, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature ______________________ Date ______________________

Printed name ______________________ Medicare Number (HICN) ______________________

I request that payment of authorized MediGap benefits be made either to me or on my behalf to Fox Valley Family Physicians for any services furnished me by that physician group. I authorize any holder of medical information about me to release to ______________________ (Name of Secondary)
any information to determine these benefits or the benefits payable for related services.

Signature ______________________ Date ______________________

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## Commercial insurance patients

I authorize the release of any medical or other information necessary to process a medical claim. I also authorize payment to be made to Fox Valley Family Physicians for any services provided to me by that physician group.

Signature ______________________ Date ______________________