

Patient Registration Form – Fayetteville & Triangle Endocrinology and Diabetes Clinic PA; (FEDC/TEDC)

Patient Information	Patient Information:			
	Last Name:		First Name:	M.I.: Previous Name (if applicable)
	Mailing Address:			Apt #
	City/State/Zip:			
	Home Phone:		Cell Phone:	Work Phone:
	Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) <input type="checkbox"/> Voice <input type="checkbox"/> Text			If Voice, Please Select Preferred Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	Family Physician or Pediatrician:		Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender
	Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other _____		Social Security #:	
	Employer Name:		Emergency Contact Name:	
	Emergency Contact Phone #:			Relationship to Patient:
Additional Information and Responsible Party	Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:			
	Last Name:		First Name:	
	Date of Birth:	Social Security #:		Phone:
	Address of Person Responsible:			
	City/State/Zip:		Relationship to Patient:	
	Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):			
	Email Address:			
	Race (please select): <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Decline		Ethnicity (please select one): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline	
	Preferred Language (please select one): <input type="checkbox"/> English <input type="checkbox"/> Sign Language		<input type="checkbox"/> Bosnian <input type="checkbox"/> Spanish <input type="checkbox"/> Indian (including Hindi & Tamil) <input type="checkbox"/> Russian <input type="checkbox"/> Other	
	Preferred Pharmacy Name & Location:			
Insurance Information	Primary Medical Insurance		Secondary Medical Insurance	
	Ins. Co. Name		Ins. Co. Name	
	Policy Holder Name:		Policy Holder Name:	
	Policy Holder's Date of Birth:		Policy Holder's Date of Birth:	
	Policy Holder's Social Security #:		Policy Holder's Social Security #:	
	Patient Relationship to Policy Holder:		Patient Relationship to Policy Holder:	
<p>I certify that I have read and agree to FEDC/TEDC payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to FEDC/TEDC all money to which I am entitled for medical expenses related to the services performed from time to time by, but not to exceed my indebtedness to FEDC/TEDC. I authorize FEDC/TEDC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A \$45.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from FEDC/TEDC by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. Comments submitted on surveys may be anonymously shared on the FEDC/TEDC Public Website.</p> <p>MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to FEDC/TEDC, I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.</p>				

I have reviewed a copy of FEDC/TEDC Privacy Notice. (Initials)

Signature of Responsible Party: **X** _____ Date: _____

Printed Name of Responsible Party: **X** _____ Date: _____