Journey
Family Medicine

New Patient Registration

Full Name (First, Middle, Last): _____ Marital Status: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ SSN: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Preferred Phone: ☐ Cell Phone ☐ Home Phone ☐ Work Phone

Date of Birth: _____ Sex: _____ Pronouns: _____

Primary Insurance Information

Insurance Name: _____ Insurance Phone: _____

Identification Number: _____ Group Number: _____

Name of Insured Party: _____ Insured Party Date of Birth: _____

Insured Party Employer : _____ Insurance Effective Date: _____

Relationship to Patient: _____ Sex (Required by insurance for billing purposes):

☐ Male ☐ Female

Secondary Insurance Information

Insurance Name: _____ Insurance Phone: _____

Identification Number: _____ Group Number: _____

Name of Insured Party: _____ Insured Party Date of Birth: _____

Insured Party Employer : _____ Insurance Effective Date: _____

Relationship to Patient: _____ Sex (Required by insurance for billing purposes):

☐ Male ☐ Female

Guarantor

Who is the guarantor? ☐ Patient ☐ Other: _____

Guarantor Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____

Emergency Contact

Name: _____ Phone Number: _____ Relationship: _____

Authorization

I authorize Journey Family Medicine Associates to bill the above insurance on my behalf, and assign any insurance benefits payable directly to Journey Family Medicine Associates. I understand that I am financially responsible for all non-covered services.

Signature: _____ Date: _____