

FRANKLIN CLINIC

PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____ Birth Date: _____ Age: _____ Marital Status: S M W D

Home Phone: _____ Work Phone: _____

Driver's License #: _____ E-Mail Address: _____

Employer: _____

Employer's Address: _____

Emergency Contact Name & Phone Number: _____

Primary Insurance Company: _____ Phone Number: _____

Name of Insured: _____ SSN of Insured: _____

Date of Birth of Insured: _____ Relationship to Insured: _____

Primary ID Number: _____ Group Number: _____

Secondary Insurance Company: _____ Phone Number: _____

Name of Insured: _____ Secondary ID Number: _____

I, the undersigned, grant permission to Dr. Martin Franklin to disclose medical information to other treating physicians regarding my care. I authorize the release to the Health Care Financing Administration or said insurance company and its agents any medical information about me to determine benefits payable for related services. I understand that I, the undersigned, am legally responsible for all fees related to medical services rendered.

I request that payment of authorized Medicare or health insurance benefits are to be made to Franklin Clinic of Dr. Martin Franklin for services furnished to me.

Patient's Signature

Date