IOWA FAMILY PRACTICE PATIENT REGISTRATION FORM

Welcome to our practice. As a new patient, please complete the following information to the best of your ability.

Patient Information:

Last Name	**First Name**	**Middle Initial**
Street Address	**City/State/Zip Code**	**SS#**
Phone Number	**Date of Birth**	**Male or Female**
Cell Phone	**Email**	**Marital Status S/M/D/W**
Emergency Contact/Phone #	**Pharmacy Name & Phone Number**	

Employer Information:

Name	**Work Number**	**Occupation**
Address	**City/State/Zip Code**	

Insurance Information:

Name of Primary Insurance Company			
Street Address	**City**	**State**	**Zip Code**
Insurance ID Number	**Local/Group Number**		

Name of Secondary Insurance Company			
Street Address	**City**	**State**	**Zip Code**
Insurance ID Number	**Local/Group Number**		

Subscriber Information: (Policyholder if different from patient)

Name	**Relationship to Patient**	**Date of Birth**
Social Security	**Address**	**Zip Code**
Home Number	**Employer's Name**	**Work Number**

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Iowa Family Practice. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature:_____ **Date:**_____