FAMILY REGISTRATION

Please print

Responsible Party

Last Name ____________________________________

First Name ____________________________M I______

Street Address _________________________________

City ______________________ State _______________

Zip Code ________________ Sex (M/F) _________

Employer _____________________________________

Address ______________________________________

City ______________________ State _______________

Zip code __________

Home Phone________________________

Work Phone________________________

Date of Birth________________________

Social Security #_____________________

Doctor______________________________

Spouses Name __________________________________

Employer _____________________________________

Address ______________________________________

City ____________________ State ______________

Zip Code ___________

Date of Birth _______________________

Social Security _____________________

Work Phone ________________________

Dependent Children's Names (include middle initial)

1. ____________________________________ Date of Birth _______________ S/S# __________________
2. ____________________________________ Date of Birth _______________ S/S# __________________
3. ____________________________________ Date of Birth _______________ S/S# __________________
4. ____________________________________ Date of Birth _______________ S/S# __________________

Medical Insurance

Name of Carrier _______________________________

Address ______________________________________

City _____________________________State __________

Zip code ___________________ Phone# ______________

Insured Party Name ______________________________

Policy# ___________________________

ID# or SS# _________________________

Medicare # _________________________

Previous Physician: ____

Who referred you to our office? ____

Authorization:

I hereby authorize medical benefits to be paid to WestGate Family Medicine and authorize them to release any information acquired in the course of my examination of or treatment for insurance purposes.

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Signature of Patient or Legal Guardian