Midnight Sun Family Medicine, P.C.
Patient Registration Form

Patient Information: **How did you find out about us? _____**

Date:	Soc. Sec #	Phone :Cell: ( )	Home: ( )
Patient's Last Name:		First Name:	M.I.
Home Address: Street	City	State	Zip
Mailing Address (if different):			
Email:			
Sex: ○ M ○ F	Date of Birth:	Marital Status:	
Patient Employed by:			
In Case of Emergency Contact:	Phone # ( )	Relationship	

If the patient is a minor (under age 18), complete the following:

Father's Name: Date of Birth:	Address	Phone # ( )
Employer:		
Mother's Name: Date of Birth:	Address	Phone# ( )
Employer:		

Who is financially responsible for this account?

Name:		
Relation to Patient:	Social Security#	
Mailing Address (if different than patient's)		Phone# ( )
Employed by:		Phone# ( )

Is the patient covered by insurance or other programs? Yes ○ No _____

1. Insurance Company/Program Name:		
Name on Card: Date of Birth:	ID#	Group #
2. Insurance Company/Program Name:		
Name on Card: Date of Birth:	ID#	Group #
3. Insurance Company/Program Name:		
Name on Card: Date of Birth:	ID#	Group #

I, the undersigned, certify that I (or my dependent) have insurance coverage with the aforementioned agencies and assign directly to Midnight Sun Family Medicine (MSFM) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize MSFM to release all information necessary to secure the payment of benefits. I understand that my account should be paid in full at the time of services.

_____ _____

Responsible Party Signature Date