PATIENT REGISTRATION
(PLEASE PRINT)

Mill Creek Family Practice

J. Seaborn Blair III, MD / Joseph S. Farmer, PA-C / Amber Lawrence, FNP-C
94 Merchants Circle
Hampstead, NC 28443
Telephone: 910-270-2515 Fax: 910-270-3544

Patient Information			
Date:	Home Phone:	Cell Phone:	Contact Preference:
Name (last, first, middle):			Email:
Address:		Marital Status:	
City:	State:	Zip:	
Gender: Male Female	Birthdate:	SSN:	
Emergency Contact Name:		Phone Number:	
Relationship to Patient:	Pharmacy:		
Language:	Ethnicity:	Race:	
How did you hear about our practice?			

Primary Insurance		
Company:	Policy #:	Group #:
Policy Holder/Guarantor Name:	please circle: Self Spouse Parent	
Birthdate of Primary Policy Holder:	SSN of Policy Holder:	

Secondary Insurance		
Company:	Policy #:	Group #:
Policy Holder/ Guarantor Name:	please circle: Self Spouse Parent	
Birthdate of Primary Policy Holder:	SSN of Policy Holder:	

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the company listed above and assign direct to Mill Creek Family Practice all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financial responsible for all changes whether or not paid by insurance. I authorize use of my signature on all insurance submissions. Mill Creek Family Practice may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable to related services.

Financial Agreement

I acknowledge that **payment is due at the time of treatment.** I understand that I am financially responsible for all charges. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges unless the contractual agreement with said company states otherwise.

I acknowledge that Mill Creek Family Practice **does not** provide pain management services.

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

Printed Name of Patient, Parent, Guardian, or Personal Representative

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