Southwest Family Physicians, Inc.

affiliated with Southwest General Medical Group

Date: ___ / ___ / ___

Patient Registration

Patient Name: _____ ☐ Male ☐ Female Birth Date: ___ / ___ / ___ Age: _____

Address: _____ City: _____ State: ____ Zip: _____

Alternate address for mailing (optional): _____

Home Phone: _____ Work Phone: _____ Social Security # : _____ - _____ - _____

For Pediatric Patients: child lives ☐ with both parents ☐ Mother ☐ Father

Mother/Guardian: _____ Address (if different): _____

Date of Birth: ___ / ___ / ___ Home Phone: _____ Work Phone: _____

Father: _____ Address (if different): _____

Date of Birth: ___ / ___ / ___ Home Phone: _____ Work Phone: _____

May we communicate with other healthcare professionals involved in your care? ☐ **Yes** ☐ **No**

_____ **All health care professionals appropriate**

_____

_____

_____ ___ / ___ / ___

Signature of Patient or Guardian Date

My Signature below acknowledges receipt of Southwest Family Physicians, Inc. Privacy Policy and Southwest General Medical Group, Inc. Financial Policy.

_____ ___ / ___ / ___

Signature of Patient or Guardian Date

I acknowledge that Southwest Family Physicians, Inc. has laboratory and radiology facilities in its office. I may choose to go elsewhere.

_____ ___ / ___ / ___

Signature of Patient or Guardian Date

For Medicare Patients: **Statement to permit payment of Medical Benefits to Provider, Physicians and Patient**

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request the payment under the medical insurance program be made either to me or SOUTHWEST GENERAL MEDICAL GROUP, INC. on any bills for services furnished me by SOUTHWEST FAMILY PHYSICIANS, INC., AFFILIATED WITH SOUTHWEST GENERAL MEDICAL GROUP, INC.

_____ ___ / ___ / ___ _____

Signature of Patient Date Health Insurance Claim Number

Information reviewed: ____/16 ____/17 ____/18 ____/19 ____/20 ____/21 ____/22 ____/23 ____/24 ____/25