FAMILY FIRST MEDICINE

902 S. Vienna St.
Ruston, LA 71273
Phone: 318-513-1950

Patient Registration Information

Today's Date____/_____/_____

How did you hear about the clinic? ____________________

What is your primary language? ENGLISH / SPANISH
Do you need an interpreter? (circle one) Yes No
Do you have a Signed Advance Directive?(circle one)Yes No

Please Indicate if you are a
_____New Patient ____Established Patient

Referring Doctor.______________
City Where Referring Doctor is located____________

PATIENT INFORMATION					
Patient Name	SS#	Marital Status: S M W D other	Sex M F	Age	Date of Birth
Street Address	City & State		Zip Code		Home Phone #
Patients Employer	Employers Address				Business Phone #

RESPONSIBLE PARTY/PARENT/LEGAL GAURDIAN-(Please complete if different from above)			
Guarantor Name	SS#	Relationship to patient	Date of Birth
Street Address	City & State	Zip Code	Home Phone #
Guarantor's Employer	Employers Address		Business Phone #

EMERGENCY CONTACT INFORMATION			
Emergency Contact Name	Relationship		Home Phone #
Street Address	City and State	Zip Code	Business Phone #

POLICYHOLDER INFORMATION (Please complete if patient is not the policyholder)			
Policyholder Name	SS#	Relationship to Patient	Date of Birth
Street Address	City & State	Zip Code	Home Phone #
Policyholder's Employer	Employer's Address		Business Phone #

INSURANCE COVERAGE *(Must be completed if copies of insurance cards are not provided)

Primary Insurance Co:______________________ ___Relationship__________ Policy #__________________
Policy Holder:______________________ ____Date of Birth__________ Group #__________________
Effective Date of Coverage__________

Secondary Insurance Co:______________________ ___Relationship__________ Policy #__________________
Policy Holder:______________________ ____Date of Birth__________ Group #__________________
Effective Date of Coverage__________

Additional Insurance Co:______________________ ___Relationship__________ Policy #__________________
Policy Holder:______________________ ____Date of Birth__________ Group #__________________
Effective Date of Coverage__________