Patient Registration Form

Patient Information

Patient Information:

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	

Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages:
(Please Select Only One Option) ☐ Voice ☐ Text

If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work

Have you been seen at Hometown Primary Care before: ☐ Yes ☐ N o

Date of Birth:

Sex: ☐ Male ☐ Female ☐ Transgender

Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other_______________________

Social Security #:

Are you Employed? **If Yes**-Employer Name:
☐ Yes ☐ N o

Emergency Contact Name:

Emergency Contact Phone #:	Relationship to Patient:	If unable to reach, do we have permission too: ☐ Voice ☐ Text

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:

Last Name:		First Name:
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:		Relationship to Patient:

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Email Address:

Race (please select):
☐ White ☐ American Indian or Alaska Native ☐ Asian
☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Other ☐ Decline

Ethnicity (please select one):
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Nepali ☐ Spanish ☐ Russian ☐ Other

Preferred Pharmacy Name:	**Location (Address & City)**

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Payment Policy Acknowledgment

I certify that I have read, understand, and agree to the Hometown Primary Care, LLC payment policy. I confirm that I am eligible for the insurance provided on this form and understand that I am financially responsible for all charges incurred, regardless of insurance coverage.

To promote clear communication and avoid misunderstandings, our staff is trained to consistently explain our financial expectations. Payment is due at the time services are rendered, unless you are covered by a prepaid plan in which we participate. For those patients, applicable copayments and deductibles are due at check-in. We accept cash, check, or credit card. Returned checks are subject to a $50.00 return fee.

It is your responsibility to verify our participation in your insurance plan, including any ancillary providers or testing, prior to your visit.

I authorize Hometown Primary Care, LLC to keep my credit card on file and to charge it for any balances owed, including copayments, deductibles, or services not covered by insurance. I understand I may revoke this authorization at any time in writing.

I give permission to receive communications from Hometown Primary Care, LLC via text, voicemail, or email at the contact information I have provided. These communications may include appointment reminders, treatment updates, billing notifications, and feedback requests. I understand that these messages may not be secure and could be accessible to third parties.

I also authorize Hometown Primary Care, LLC to release any information necessary to process my insurance claims to the listed insurance carriers, the Social Security Administration, or their intermediaries. I permit a copy of this authorization to be used in place of the original and request that payment of medical insurance benefits be made directly to Hometown Primary Care, LLC.

Patients Legal Name: (Print) ____ **Date:**_________________________

Patient or Responsible Persons Signature: ____ **Date:** _________________________