Golden Rule Family Practice®
Healthcare the way *you* want it.

New Patient Registration Form

Date_____ Home Phone_____ Mobile Phone_____
Email_____

Patient (Last, First) _____

Responsible Party (If a Minor) _____

Street Address_____

City_____ State _____ Zip Code_____

Gender ☐ M ☐ F Age_____ Birthdate_____ Marital Status _____

Patient Employed By _____

Business Address_____

Occupation _____ Business Phone _____

Who is the Responsible for this Account? _____ Relationship to Patient _____

Social Security #_____ Spouse's Social Security # _____

Driver's License # _____ State Issued _____

Do you Have Medical Insurance? _____

Name of Primary Insurer _____ PPO Network _____

Insured Name _____ Group # _____ Member ID # _____ Copay _____

Name of Secondary Insurer (If any) _____ PPO Network _____

Insured Name _____ Group #_____ Member ID #_____ Copay _____

☐ Medicare Medicare # _____

In Case of Emergency, Who should be notified? _____

Relationship _____ Phone Number _____

Whom may we thank for referring you to Golden Rule Family Practice®? _____

Assignment and Release

I, the undersigned, have coverage with _____and assign directly to Golden Rule Family Practice®, all medical 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 the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all my insurance submissions.

Signature of Insured/Guardian_____ Date_____