



2011 MINOR REGISTRATION
Account No.: _____
TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN ONLY

Thank you for choosing FirstCare. How did you hear about our clinic?
 By Friend Phone Book Newspaper Radio Internet TV Sign
 Brochure

Patient Name : Last	Suffix	First	M.I.	PATIENT INFORMATION
Mailing Address	City	State	Zip Code	
Male/Female	Date of Birth	Age	Social Security no.	

Name of Person Responsible for the Bill	Last	Suffix	First	M.I.	GUARANTOR INFORMATION
Mailing Address	City	State	Zip Code		
Male/Female	Marital Status		Relationship to Patient		
Employer	Birth Date		Social Security #		

CONFIDENTIAL COMMUNICATION – FirstCare Medical Centers, LLC. attempts to contact patients 48-72 hours after a visit to ensure the best medical care possible. These calls may include lab or x-ray result, or general questions about well-being.
By initialing, I hereby opt out any routine calls made by FirstCare’s clinical staff. I do not wish to be contacted. I will be responsible for contacting FirstCare for health questions or to obtain any test results. _____ (Patient Initials)

Home Phone No. _____ Cellular Phone No. _____

Work Phone No. _____ Written Communication: (Please circle one)
 Mail to my home address: YES NO

INSURANCE COVERAGE					
Is Patient Eligible for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No			Medicaid ID # _____		
Father’s / Guardian’s Name			Mother’s / Guardian’s Name		
Last	Suffix	First	M.I.	Last	Suffix
Address			Address		
Social Security No.		Date of Birth		Date of Birth	
Employer			Employer		
Work Phone no.		Home Phone no.		Home Phone no.	
Insurance Company			Insurance Company		
Insurance Address			Insurance Address		
Insurance Phone no.			Insurance Phone no.		
Policy no.			Policy no.		
Group no.			Group no.		
Circle if Primary or Secondary Insurance P S			Circle if Primary or Secondary Insurance P S		

Emergency Contact: (Last, First, M.I.) _____ Phone Number _____ Relationship: _____

Consent is hereby given to **FirstCare Medical Centers, LLC.** and the treating physician/nurse practitioner to administer such treatment and to perform such medical and/or surgical procedures which are deemed necessary. I authorize my insurance benefit to be paid direct to **FirstCare Medical Centers, LLC.** I understand that I am financially responsible for any unpaid balance, and should I not pay **FirstCare Medical Centers, LLC.** and my account is sent to collection, I understand that I am financially responsible for any collection agency fees. I authorize **FirstCare Medical Centers, LLC.** to release any information required for my insurance claim. Charges are all tentative until reviewed by an auditor.

Signature of Patient or Guardian of Minor Child: _____
Relationship of Patient: _____ **Date:** _____