



## Patient Registration

Patient Name : \_\_\_\_\_ Date Of Birth : \_\_\_\_\_  
 Address : \_\_\_\_\_ Social Security # : \_\_\_\_\_  
 City : \_\_\_\_\_ State : \_\_\_\_\_ Zip : \_\_\_\_\_ Sex : \_\_\_\_\_  
 Home Phone : \_\_\_\_\_ Cell Phone : \_\_\_\_\_ Work Phone : \_\_\_\_\_  
 Occupation : \_\_\_\_\_ Employer : \_\_\_\_\_

Guarantor Name : \_\_\_\_\_ Date Of Birth : \_\_\_\_\_  
 Address : \_\_\_\_\_ Social Security # : \_\_\_\_\_  
 City : \_\_\_\_\_ State : \_\_\_\_\_ Zip : \_\_\_\_\_ Sex : \_\_\_\_\_  
 Home Phone : \_\_\_\_\_ Cell Phone : \_\_\_\_\_ Work Phone : \_\_\_\_\_  
 Occupation : \_\_\_\_\_ Employer : \_\_\_\_\_

Primary Insurance Company : \_\_\_\_\_  
 Name Of Insured : \_\_\_\_\_ SS# : \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 Policy # : \_\_\_\_\_ Group # : \_\_\_\_\_ Copay Amount : \_\_\_\_\_ Deductible Amount : \_\_\_\_\_  
 Relationship To Patient :  Self  Guarantor  Other \_\_\_\_\_

Secondary Insurance Company : \_\_\_\_\_  
 Name Of Insured : \_\_\_\_\_ SS# : \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 Policy # : \_\_\_\_\_ Group # : \_\_\_\_\_ Copay Amount : \_\_\_\_\_ Deductible Amount : \_\_\_\_\_  
 Relationship To Patient :  Self  Guarantor  Other \_\_\_\_\_

Emergency Contact : \_\_\_\_\_ Relationship To Patient : \_\_\_\_\_  
 Home Phone : \_\_\_\_\_ Cell Phone : \_\_\_\_\_ Work Phone : \_\_\_\_\_

I/We hereby state that the information above is true and correct to the best of my/our knowledge.

I/We authorize Agave Family Physicians, PLLC to release any information including diagnosis and treatment of the patient named above to third party payors and/or other healthcare practitioners as required for claims filed.

I/We authorize the insurance carrier(s) named above to make direct payment to Agave Family Physicians, PLLC for any and all medical or surgical services rendered by Agave Family Physicians, PLLC.

I/We understand that copayments are due at the time of service. I/We also understand that, if any charges not covered by if the insurance carrier/s named above, I/we are responsible for the balance due.

I/We understand that, if my insurance information cannot be verified, I/we are responsible for the entire balance due.

In the case of default on payment of my/our account, I/we agree to pay collection costs and reasonable attorney fees incurred in attempting to collect the balance due on my/our account.

I/We understand that, if payment made by check is returned by the bank for insufficient funds, I/we will be charged a \$25.00 dishonored check fee in addition to the original fees. I/we further understand that payment must be made in cash, certified funds or credit card.

In the event that I/we miss an appointment without providing 24 hour prior notice, I/we understand and agree that I/we may be charged a \$25.00 rescheduling fee before my/our appointment will be rescheduled.

I/We acknowledge that I/we have been presented with a copy of the Agave Family Physicians, PLLC Notice Of Privacy Practices.

I/We grant permission for any representative from Agave Family Physicians, PLLC to leave messages regarding my/our medical care at the phone numbers listed above.

\_\_\_\_\_  
Signature Of Patient/Guarantor

\_\_\_\_\_  
Date