

**PATIENT REGISTRATION**  
**CHAPEL HILL FAMILY MEDICINE, P.A.**

120 Conner Drive • Suite 200 • Chapel Hill, NC 27514 (919) 967-8291 (Phone)  
(919) 967-3627 (Fax)

**PATIENT**

Last: \_\_\_\_\_ First: \_\_\_\_\_ Initial: \_\_\_\_\_  
Sex: M or F Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ S.S. #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Referred By: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
Emergency Contact and Phone #: \_\_\_\_\_  
\_\_\_\_\_

**GUARANTOR**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Relationship: \_\_\_\_\_ S.S. # \_\_\_\_\_ D.O.B. \_\_\_\_\_

**INSURANCE**

Name of Insurance \_\_\_\_\_  
Primary  
Policy Holder \_\_\_\_\_ Policy # \_\_\_\_\_ Address \_\_\_\_\_  
Name of Insurance \_\_\_\_\_  
Secondary  
Policy Holder \_\_\_\_\_ Policy # \_\_\_\_\_ Address \_\_\_\_\_

**SPOUSE**

Name: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work Address: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ S.S. # \_\_\_\_\_ D.O.B. \_\_\_\_\_

**OTHER**

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION:**  
I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I also authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Patient X \_\_\_\_\_ Date \_\_\_\_\_  
Verified By \_\_\_\_\_ Date \_\_\_\_\_