

**Junction City/Harrisburg Medical Clinic  
Patient Registration Form**

Address change: Yes No

Insurance change: Yes No

Account # \_\_\_\_\_

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_  
street city state zip code

Home # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Are you a new patient? Yes No Has anyone in your immediate family been a patient in this clinic? Yes No  
If yes, please list the name and relationship? \_\_\_\_\_

Spouse's information if married:

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_  
street city state zip code

Home # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Does your insurance require a primary care physician? Yes No If, yes which physician below have you chosen?  
\_\_\_\_ Douglas Bailey, MD \_\_\_\_ Justin Montoya, MD \_\_\_\_ Howard Stein, DO \_\_\_\_ Arthur Willey, MD

**Primary Insurance Company:** \_\_\_\_\_ Co-pay: \$ \_\_\_\_\_

Address \_\_\_\_\_  
street city state zip code

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Social Security # \_\_\_\_\_

Policy Holder Phone #: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_ Co-pay: \$ \_\_\_\_\_

Address \_\_\_\_\_  
street city state zip code

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Social Security # \_\_\_\_\_

Policy Holder Phone #: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

**PERSONS TO CONTACT IN CASE OF EMERGENCY:**

Please list at least one individual NOT living with you.

Name: \_\_\_\_\_ Phone # ( \_\_\_\_\_ ) Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone # ( \_\_\_\_\_ ) Relationship: \_\_\_\_\_

Is there a designated person that you authorize to bring your child in for **emergency care**? Yes No

Name: \_\_\_\_\_ Phone # ( \_\_\_\_\_ ) Relationship: \_\_\_\_\_

Address \_\_\_\_\_  
street city state zip code

**PLEASE READ AND SIGN:**

I hereby consent to medical treatment as determined by my medical provider. I authorize payment of medical benefits to Junction City/Harrisburg Medical Clinic. I understand that I am financially responsible for all charges, whether or not they are paid by insurance. I hereby authorize the release of any medical information necessary for the payment of benefits. I further agree to pay all costs of collection and resonable attorney fees, in the case of default of my financial obligation with this clinic.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
patient or responsible party

- \* Insurance co-payments are due when checking in at each visit
- \* I you are unable to make it to your appointment, please call as soon as possible. Less than 24 hours notice may be counted as a **no-show** and 3 no-shows could have you dismissed from the clinic.
- \* Please present new insurance cards, change of address or phone number, or any other change to the information on this form to the front desk when checking in.