Highland Primary Care
515 Suite A Lauchwood Dr, Laurinburg NC 28352
Office: 910-506-4510 Fax: 910-506-4527

Patient Registration Form

Patient Information

Patient Information			
Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred Method of Contact for reminder calls and other electronically generated messages: (Please Select Only One Option) ☐ Voice ☐ Text			If Voice, Please Select Preferred Number : ☐ Home ☐ Cell ☐ Work
Date of Birth:	Sex: ☐ Male ☐ Female		Family Physician or Pediatrician:
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:			Relationship to Patient:

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor		
Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**	
Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I have read and agree to Highland Primary Care's (HPC) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to HPC all money to which I am entitled for medical expenses related to the services performed from time to time by HPC, but not to exceed my indebtedness to HPC. I authorize HPC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $35.00 returned check fee will be charged for checks returned due to insufficient funds. By choosing text messaging and/or email as a communication method, I acknowledge that Highland Primary Care is not liable for any wireless charges I may incur and that unencrypted patient information may be sent to me via text message or email.
MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to HPC. I authorize any holder of medical information about me to release to HPC and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Highland Primary Care's Privacy Notice. **(Initials)**

Signature of Responsible Party: X ______________________ **Date:**

Printed Name of Responsible Party: X ______________________ **Date:**