



ATHENA FAMILY MEDICINE

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Kevin Vo, MD

Board Certified

Family Medicine

PATIENT REGISTRATION

PATIENT INFORMATION

Last name	First name	M.I.	Previous name (if any)		
Mailing address		Apt #	City	State	ZIP
Home phone		Cell phone	Work phone		
Date of birth	Sex: ☐ Male ☐ Female	Marital status		Social Security # (optional)	
Appointment reminders by: ☐ Phone call ☐ Text message If phone call, which number: ☐ Home ☐ Cell ☐ Work			Employer		
Emergency contact name		Emergency contact phone		Relationship to patient	
Previous doctor (name and city)			Preferred pharmacy (name and location)		

RESPONSIBLE PARTY (GUARANTOR) — if patient is under 18 or someone else pays

Last name	First name	Date of birth	Phone
Address (if different from patient)		City / State / ZIP	Relationship to patient

ADDITIONAL INFORMATION

Email address	May we leave a message about your care and test results? ☐ Yes ☐ No
Race (check all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Prefer not to answer	
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer	Preferred language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: _____
How did you hear about us? ☐ Google search ☐ Friend or family ☐ Insurance directory ☐ Another doctor ☐ Online ad ☐ Other: _____	

INSURANCE INFORMATION

PRIMARY insurance company	SECONDARY insurance company
Policyholder name and date of birth	Policyholder name and date of birth
Patient relationship to policyholder	Patient relationship to policyholder
Member ID # Group #	Member ID # Group #

Financial responsibility and assignment of benefits. I have read and agree to the Athena Family Medicine (AFM) Office Policy. I understand that I am responsible for payment regardless of insurance coverage. I assign to AFM all insurance benefits I am entitled to for services provided by AFM, not to exceed the amount I owe. I authorize AFM to release medical information to my insurance company or other payer as needed to process my claims. I understand that balances not paid within 90 days of notice may be sent to an outside collection agency.

Medicare beneficiaries. I request that payment of authorized Medicare benefits be made to AFM on my behalf. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Text and email. If I choose text messages or email, I understand these messages may not be encrypted and I accept that risk. My carrier's standard rates may apply.

I have received or reviewed Athena Family Medicine's Notice of Privacy Practices. Initials: _____

Signature of patient or responsible party

Printed name

Date