Independent Family Doctors
1711 Gold Drive South, Suite #160
Fargo, ND 58103
(701) 234-9400 • Fax (701) 234-9401

Registration

For Office Use
Chart # _____
Provider # _____
Updated _____

Patient Name: _____ (Last / First / M.I.)
Address: _____ (Street / City / State / Zip Code)
Phone: _____ **Sex:** M F **Marital Status:** S M D W
Date of Birth: _____ **Soc. Security:** _____
Employer: _____
_____ (Address / Phone / Ext)
Cell #: _____ **Beeper:** _____ **Fax:** _____
Emergency Contact: _____ (Name / Phone / Relation)
Student Status: _____ **E-Mail Address:** _____

Policyholder: _____
Sex: M F **Soc. Security:** _____ **Date of Birth:** _____
Policyholders Employer: _____
_____ (Address / Phone / Ext)

Living Will?: Y N _____ **Organ Donor?:** Y N

Responsible Party: _____ (Relationship)
_____ (Responsible Party Address / City/State / Phone)
Sex: M F **Social Security #:** _____ **D.O.B.:** _____
Employer of Responsible Party: _____ (Employer of Responsible Party / Employer Address / Phone)

Insurance Company: _____
_____ (Address)
_____ (Policy Number / Policyholder)

What is the VFC Program?

• Vaccines for Children is a federal program that provides vaccines to children 18 years and younger who meet one of the following criteria
PLEASE CHECK THE ONE THAT APPLIES

- ❑ Medicaid eligible (including those with Medicaid as a secondary insurance)
- ❑ American Indian or Alaska Native (considered VFC, even if the child has insurance)
- ❑ No Insurance
- ❑ Underinsured: has insurance, but insurance does not cover vaccinations (must be vaccinated at a Federally Qualified Health Center or Rural Health Center; also served by those Providers who have signed memorandum of understanding (MOU)
- ❑ None are applicable

Signature _____ Date _____

IMPORTANT INFORMATION . . . PLEASE READ CAREFULLY

1. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
2. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
3. I understand and agree that I will be responsible for the payment of any services not covered by payments from any insurance companies or other third parties.

_____ (Signature (Parent or Legal Guardian)) _____ (Date)

The above signature includes all services provided at Independent Family Doctors for an unspecified period of time.