PATIENT REGISTRATION FORM

Date:___________

PATIENT INFORMATION

Name (First, MI, Last) ____

Address ____ City, State, Zip _______________________

Phone# _____________________________ Work Phone# ________________________________

Fax#_______________________________ Cell Phone: _________________________________

E-mail Address ____

Sex ________ Date of Birth ____________________ Social Security Number ____________________________

Referring Doctor ____

Primary Care Physician ____

WHO SHOULD BE NOTIFIED IN AN EMERGENCY?

Name _________________________________ Relation ______________ Phone# ____________________ Cell# ____________________

PRIMARY INSURANCE INFORMATION

Insurance Company Name ____

Address ____ City, State, Zip __________________________________

Insured's Name (First, MI, Last) ____

Address ____ City, State, Zip _________________________________

Sex ___________ Date of Birth _____________________ Social Security Number _________________________

ID Number ____________________________

Employer ____

Address ______________________________________ City, State, Zip _____________________________________

Insurance Company Contact ______________________________ Phone# _________________________________

SECONDARY INSURANCE INFORMATION

Insurance Company Name ____

Address ______________________________________ City, State, Zip _____________________________________

Insured's Name (First, MI, Last) ____

Address ____ City, State, Zip _____________________________________

Sex _________ Date of Birth ________________________ Social Security Number ________________________________

ID Number _______________________________

Employer ____

Address ______________________________________ City, State, Zip ____

Insurance Company Contact _______________________________________ Phone# _________________________________

Are you currently receiving any public health services? __________________

Is the problem your being seen for today a result of a work related injury or an automobile accident? _________ Date Of Injury ___________

ASSIGNMENT AND RELEASE

I authorize the release of any medical information necessary to process insurance claims, and the release of information back to my physician.

Signed: ____ Date: ________________________

I request that payment of authorized Medicare benefits be made either to me or my behalf to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to release to the center for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signed (Medicare Beneficiary): ____ Date: ______________________