# Patient Registration Form

Primary Care Physician: ________________________________ Phone No. ____________________ Today's Date: _______________

**PATIENT INFORMATION** **(Please Print)**

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Jr. ❑ Sr. ❑ Other_______________

Patient's Name (Last) _____________________________ (First)______________________ (Middle)____________________

Also Known As Name (Last) __________________________________________ (First) ______________________________________

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Other

Social Security Number ________-_____-___________ ❑ Female ❑ Male Date of Birth_________/_________/_________

E-Mail Address _______________________________________ ❑ Check here if you do not wish to receive routine mailings and surveys

Phone Numbers Home ___________________ ❑ Day ❑ Evening Work_____________________ ❑ Day ❑ Evening

Cellular ___________________ Pager ____________________

Address ____________________________________________________________________________________________________

City, State, ZIP (+4) _____________________________________________________________________________________________

Employment Status ❑ Employed Full-Time ❑ Employed Part-Time ❑ Student Full-Time ❑ Student Part-Time ❑ Retired ❑ Self-Employed ❑ Unemployed

Employer __________________________________________________ Occupation ____________________________________

Emergency Contact Name _____________________________________ Patient Relationship to Emergency Contact _________________

Emergency Contact Phone Number ________________________________

**RESPONSIBLE PARTY INFORMATION**

Responsible Party Name (Last)______________________ (First)______________________ (Middle)____________________

Also Known As Name (Last) __________________________________________ (First) ______________________________________

Social Security Number ________-_____-___________ ❑ Female ❑ Male Date of Birth_________/_________/_________

E-Mail Address ____________________________________________________________________________________________

Phone Numbers Home ___________________ ❑ Day ❑ Evening Work_____________________ ❑ Day ❑ Evening

Address ____________________________________________________________________________________________________

City, State, ZIP (+4) _____________________________________________________________________________________________

Employment Status ❑ Employed Full-Time ❑ Employed Part-Time ❑ Student Full-Time ❑ Student Part-Time ❑ Retired ❑ Self-Employed ❑ Unemployed

Employer __________________________________________________ Employer Phone Number ___________________________

Patient Relationship to Responsible Party _____________________________________________________________________

**PRIMARY INSURANCE INFORMATION** (provide your insurance card to the front desk at check-in)

Name of Insured ____________________________________________ Patient Relationship to Insured ______________________

Social Security Number ________-_____-___________ ❑ Female ❑ Male Insured Date of Birth_________/_________/_________

E-Mail Address ____________________________________________________________________________________________

Insurance Company _____________________________________________________________ (_______) __________________

Subscriber ID (Policy Number) ___________________ Group ID___________________ Copay Amount____________________

Effective Date ____________________ Termination Date ________________________

Insurance Company Address _______________________________________________________________________________

**SECONDARY INSURANCE INFORMATION** (provide your insurance card to the front desk at check-in)

Name of Insured ____________________________________________ Patient Relationship to Insured ______________________

Social Security Number ________-_____-___________ ❑ Female ❑ Male Date of Birth_________/_________/_________

E-Mail Address ____________________________________________________________________________________________

Insurance Company _____________________________________________________________ (_______) __________________

Subscriber ID (Policy Number) ___________________ Group ID___________________ Copay Amount____________________

Effective Date ____________________ Termination Date ________________________

Insured Date of Birth_________/_________/_________ Insurance Company Address ________________________________________

I agree that the information on this form is accurate and up-to-date to the best of my knowledge.

***Patient (or Responsible Party) Signature*** ___________________________________________________ ***Date***_________________

**(PLEASE TURN OVER)**

# AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance, however you are responsible for your copay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physicians when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable. I ______________________________ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

______________________________ ______________________

Signature Date

I authorized this facility to release information to (Please check all that apply):

- ❑ Spouse: List complete name of spouse ______________________________
- ❑ Children: List complete names of children & phone numbers ______________________________
- ❑ Others: List complete name & phone number of person designated ______________________________
- ❑ No One

______________________________ ______________________

Signature Date

## Medicare Patients

I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for any services furnished me by the provider. I authorize any holder of medical information about me; to release Medigap Insurer______________________________any information needed to determine those benefits payable for related services.

______________________________ ______________________

Signature Date

# MEDICARE LIFETIME AUTHORIZATION

HIC#______________________

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct and authorize any holder of the medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians services to the physician or organization furnishing the services or authorized such physician or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurances.

Signed: ______________________ Date: ______________________

Print Name: ______________________ Title or Relationship: ______________________

Witnessed by: ______________________ Address: ______________________

If signed by other than beneficiary, state reason the patient was unable to sign:______________________________