Patient Registration

(Please Print)

PATIENT INFORMATION

Please present your insurance card at each visit.

(First Name) (Middle Initial) (Last Name)

(Street Address)

(City, State) (Zip Code)

(Phone Number) (Cell Phone Number)

(E-mail Address) (Date of Birth)

(Sex) (Marital Status) (Social Security Number)

(Employer Name)

(Employer Address)

(Employer City, State) (Zip Code)

(Employer Phone Number)

(Primary Physician)

(Emergency Contact Name)

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black, African American ☐ Native Hawaiian, Other Pacific Islander ☐ White ☐ Unknown ☐ Declined

ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Unknown ☐ Declined

LANGUAGE: ☐ English ☐ Spanish ☐ French ☐ German ☐ Chinese ☐ Other_____

(Patient's Occupation)

(Emergency Phone Number) (Relationship to Patient)

GUARANTOR INFORMATION (If guarantor is the same as patient, omit this section.)

(First Name) (Middle Initial) (Last Name)

(Street Address)

(City, State) (Zip Code)

(Phone Number) (Marital Status)

(Social Security Number) (Date of Birth)

(Employer Name)

(Employer Address)

(Employer City, State) (Zip Code)

(Employer Phone Number)

(Cell Phone Number)

INSURANCE INFORMATION (SUBSCRIBER)

PRIMARY INSURANCE_____

Address_____ City/State_____ Zip_____

Who holds insurance _____ Birthdate_____

Relationship to Patient_____ Policy # _____ Group # _____

Employer_____ SS# _____ Work Phone_____

SECONDARY INSURANCE_____

Address_____ City/State_____ Zip_____

Who holds insurance _____ Birthdate_____

Relationship to Patient_____ Policy # _____ Group # _____

Employer_____ SS# _____ Work Phone_____

HOW WERE YOU REFERRED TO US?

(Please check how you were referred to our clinic.)

☐ Yellow Pages ☐ Newspaper

☐ Physician ☐ Insurance

☐ Advertising ☐ Family & Friends

ADVANCED DIRECTIVE / LIVING

Would you like information regarding Advanced Directives?

☐ Yes ☐ No

Please be advised that we will initiate CPR and dial 911 when a patient is in distress.

CONSENT FOR TREATMENT

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled, including Medicare, private insurance and other health plans, to this practice. I understand it is my responsibility to pay any deductible and/or co-pay amount, and that I am financially responsible for all charges whether or not paid by insurance. I have been informed that some lab studies may go to an outside lab, and I may receive a separate bill for these services. The practice is authorized to use my medical information in its quality assurance and utilization review programs, and may disclose such information for medical research purposes.

Signature_____ **Date** _____

What is the best phone number to contact you? _____