

PATIENT REGISTRATION A

Referred by: _____ **Family doctor:** _____

Patient Name. _____ Today's Date _____
Last First Middle

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail address _____ Marital Status Single Married Divorced Widowed

Social Security Number _____ Date of Birth _____ Age _____ Gender M F

Employer/Parent's Employer _____ Occupation _____

Work Address _____ Work Phone _____

City _____ State _____ Zip Code _____

Spouse name (Parent name if minor) _____ Spouse/Parent Work Phone _____

Person to notify in case of emergency (other than spouse) _____

Phone number (s) _____ Relationship _____

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		Relationship to Patient
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		Relationship to Patient
Social Security Number	Date of Birth	Employer

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to (Practice Name) to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

Patient's signature

Today's date

PATIENT REGISTRATION B

PATIENT_007 | Rev_01-2018



 Preferred Pharmacy Street Address City State () Phone #

PHYSICIAN INFORMATION:

_____	_____	_____	_____	() _____
Primary Care Physician	Street Address	City	State	Phone #
_____	_____	_____	_____	() _____
Other Physician's Name and Specialty	Street Address	City	State	Phone #
_____	_____	_____	_____	() _____
Other Physician's Name and Specialty	Street Address	City	State	Phone #

INSURANCE INFORMATION: (Please give insurance cards to receptionist to copy)

Primary Insurance: _____ Owner Name: _____

Secondary Insurance: _____ Owner Name: _____

Third Insurance: _____ Owner Name: _____

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of _____ to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, friend)

<u>Name of Person or Entity:</u>	<u>Relationship:</u>
_____	_____
_____	_____
_____	_____
_____	_____

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

_____ Signature of the Patient or Patient Representative

I have been provided a copy of the Financial Policy to read. I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

_____ Signature of the Patient or Patient Representative

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to _____

_____ Signature of the Patient or Patient Representative