

Patient Account Number

PATIENT REGISTRATION FORM

NEW
 CHANGE

Date

PATIENT INFORMATION					
LAST NAME	FIRST NAME	MI	SEX	REFERRING DOCTOR	
SOCIAL SECURITY #	DATE OF BIRTH	AGE	HOME PHONE #	WORK PHONE #	
STREET ADDRESS (please include apt #, if that applies)			EMPLOYER NAME		
CITY	STATE	ZIP	EMPLOYER ADDRESS		
CELL PHONE #/OR PAGER	SEASONAL PHONE #	MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		STUDENT STATUS <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not a student	
EMAIL ADDRESS (if you are interested in receiving health related and/or billing information via email*)					

GUARANTOR OF INSURANCE, IF OTHER THAN PATIENT					
LAST NAME	FIRST NAME	MI	SEX	PATIENT'S RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	
SOCIAL SECURITY #	DATE OF BIRTH	HOME PHONE #	WORK PHONE #		
STREET ADDRESS (please include apt #, if that applies)			EMPLOYER NAME		
CITY	STATE	ZIP	EMPLOYER ADDRESS		

NOTICE OF PRIVACY PRACTICES (HIPAA)

MY SIGNATURE BELOW INDICATES THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES

Patient Signature:	If other than patient, please print name:									
Please list the person(s) and relationship that your physician &/or staff may speak with regarding your health if necessary:										
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Person</td> <td style="width: 20%;">Phone #</td> <td style="width: 10%;">Relationship</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>Person</td> <td>Phone #</td> <td>Relationship</td> </tr> </table>	Person	Phone #	Relationship				Person	Phone #	Relationship	Please indicate if someone other than previously stated should be contacted in the case of an EMERGENCY:
Person	Phone #	Relationship								
Person	Phone #	Relationship								
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Name</td> <td style="width: 20%;">Phone #</td> <td style="width: 10%;">Relationship</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>	Name	Phone #	Relationship						
Name	Phone #	Relationship								
	If other than home, please indicate the phone number that we may leave a confidential message at:									

PHARMACY NAME:	PHARMACY PHONE NUMBER:
If available, do you usually have your prescriptions delivered? Y / N	

PAYMENT POLICY

All professional services rendered are charged to the patient (or the person financially responsible). Necessary forms will be completed to expedite insurance payments. The patient is responsible for all fees, regardless of insurance coverage. It is necessary to pay for services rendered, at the time of service, unless other arrangements have been made. **Patients with a copay are required to pay the copay at the time of service.** I understand that I am responsible for any amount not covered by insurance. **I agree to pay any balance due, in full, within 10 days of the statement, unless other arrangements have been made in advance.** If payment is NOT made in a timely manner and collection action becomes necessary, the signature below shall serve as authorization to release any information necessary to the collection agency selected by the medical provider(s) who have treated me.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the release of any medical or other information (necessary to process this claim) to my insurance carrier. I also request payment of government benefits (if any apply) either to myself, or to the party who accepts assignment. Furthermore, I authorize payment of medical benefits directly to the medical provider(s) who have treated me or rendered me or rendered services or materials.

***AUTHORIZATION FOR RELEASE OF INFORMATION TO EMAIL ADDRESS**

We collect email addresses for the purpose of notifying patients of business announcements. We may collect and use personal data for the additional purpose of sending advertisements pertaining to specific medical conditions. We do not disclose your personally identifiable data to any other subsidiaries or organizations, other than for the purposes mentioned in the paragraph above entitled INSURANCE AUTHORIZATION AND ASSIGNMENT.

Signature: _____ **Date:** _____

A copy of this authorization shall be as valid as the original.

****There is a \$20 fee for any FMLA/INSURANCE PAPERS FILLED OUT – allow 2 weeks for completion.****