

PATIENT REGISTRATION FORM

NAME: LAST FIRST MIDDLE JR / SR
MARITAL STATUS: S M D SINGLE MARRIED DIVORCED
ADDRESS CITY STATE SS# DATE OF BIRTH: AGE
ZIP CODE MALE FEMALE SEX (PLEASE CIRCLE)
EMPLOYER: ADDRESS WORK PHONE:
EMAIL FOR PRACTICE UPDATES AND INFORMATION

INSURED Spouse/Parent/Guardian

NAME: SS#: BIRTHDATE:
EMPLOYER: ADDRESS:
1) INSURANCE COMPANY: ID#: ADDRESS:

WERE YOU REFERRED BY A PHYSICIAN? IF YES, PLEASE GIVE NAME:

This office does not submit claims to your insurance company unless you are on Medicare, Anthem, Humana, Medical Mutual or Aetna. You must submit the HCFA form, given to you at the time you check out, to your insurance carrier. Medicare HMO patients will be responsible for all charges for services rendered. Our physicians are participating providers with Medicare, Anthem, Humana, Medical Mutual and Aetna. We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient and he/she is financially responsible for these charges. We do not accept Medicaid. Your signature below acknowledges your understanding of these policies. In addition, the Health Care Insurance Portability and Accountability Act (HIPAA) requires this practice to publish a Notice of Privacy Practices which describes how your health information may be used and disclosed for the normal healthcare operations of this practice (including the release of information for billing and collection purposes as well as to another healthcare provider for purposes related to your treatment). Your signature below signifies that a copy of this Notice has been made available to you.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

Do you wish us to leave personal medical and/or billing information on your answering machine? [] yes [] no

In the event of an emergency, who may we contact to inform them of your condition?

Name: Relationship: Phone Number:

May we discuss your medical information with family members? [] yes [] no if yes,

Name: Relationship: Phone Number:

SHOULD MY ACCOUNT FALL INTO ARREARS GREATER THAN 60 DAYS, I AUTHORIZE THE UNPAID BALANCE TO BE CHARGED TO MY MAJOR CREDIT CARD AS LISTED BELOW:

VISA MASTERCARD DISCOVER CARD NUMBER EXP. DATE 3 DIGIT PIN

NAME AS IT APPEARS ON CARD SIGNATURE DATE