

PATIENT REGISTRATION FORM

NAME: _____ JR / SR
LAST FIRST MIDDLE

ADDRESS _____

CITY STATE _____

ZIP CODE _____

EMPLOYED: YES NO

EMPLOYER: _____

ADDRESS _____

MARITAL STATUS: _____
S M D
SINGLE MARRIED DIVORCED

SS#: _____

DATE OF BIRTH: _____

HOME/DAY PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

SEX (PLEASE CIRCLE) _____
MALE FEMALE

AGE _____

INSURED Spouse/Parent/Guardian

NAME: _____ SS#: _____ BIRTHDATE: _____

EMPLOYER: _____ ADDRESS: _____

1) INSURANCE COMPANY: _____ ID#: _____ ADDRESS: _____

2) 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 or Medical Mutual. 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 and Medical Mutual. 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 operation 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 _____

May we leave personal medical information on your answering machine at home? yes no

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 EXPIRATION DATE

NAME AS IT APPEARS ON CARD SIGNATURE DATE