

PATIENT INFORMATION

Master Registration

Please Print

Date: _____ Account: _____

Patient Name: _____

Last

First

Middle

Maiden Name: _____ Prior Married Name: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Address: _____

Mailing and Physical Address

City: _____ St.: _____ Zip: _____

Soc. Security: _____ Home Phone #: _____

Work Phone# _____

Cell Phone # _____

Family Physician: _____ Reason for Visit: _____

Known allergies _____

Referring Name _____

Responsible Party & Address: _____

Patients Employer Name / Address: _____

Occupation: _____

Spouse's Name: _____ Spouse's Birthdate: _____

Spouse's Social Security: _____

Spouse's Employer Name: _____

Employers Address: _____

Nearest Relative to Patient: _____ Relationship: _____

Phone # _____

Concerning Insurance

I hereby authorize this physician to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or, in the case of Medicare Part B benefits to the social security administration and health care financing administration). A copy of the authorization may be used in place of the original. This authorization may be revoked by either me or my insurance carrier at any time in writing.

Signature of Patient, Insured or Beneficiary

Date

Assignment of Benefits

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this physician for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original.

Signature of Patient, Insured or Beneficiary

Date

Financial Responsibility

In the event my unpaid account must be turned over for collection, I understand I will be responsible to pay all reasonable costs of collection, including attorney's or collection agency's fees.

Signature of Patient, Insured or Beneficiary

Date

Regarding Laboratory Fees

Medicare, Medicaid, Blue Shield and certain insurance companies require you to be informed in advance that there may be certain laboratory procedures which may

not be covered because the carrier may determine that the service is not "reasonable and/or necessary ". It must be emphasized that in your physicians's professional judgment these services are needed in order to render high quality medical care to you. However, in order for you to make an informed decision, you are advised that based on insurance guidelines, it is possible that your carrier may deny certain procedures. By signing this statement, you are agreeing to pay for laboratory tests, even if your carrier determines that according to it's guidelines the services are not "reasonable and/or necessary."

Signature of Patient, Insured or Beneficiary

Date

I have received and reviewed a copy of the HIPPA privacy notice.

Signature of Patient, Insured or Beneficiary

Date

Request For Restrictions And Sharing Of Information With Persons
Other Than The Patient

I, _____, request the following restrictions to the use or
(Patients Name)
disclosure of my protected health information.

The organization may discuss my medical condition/information with the following:

	Yes	No
Spouse	___	___
Parents	___	___
Children	___	___
Friends	___	___

If this is yes for one or more and no for one or more, Please list those whom we may not discuss information With.

Please specifically list the names of friends that we may Talk with concerning your protected health Information.

Name of Person	Relationship
_____	_____
_____	_____