

Insurance cards copied

Date: \_\_\_\_\_

# Patient Registration Information

Account #: \_\_\_\_\_

Chart #: \_\_\_\_\_

Please PRINT AND complete ALL sections below!

Is your condition a result of a work injury? YES NO      An auto accident? YES NO      Date of injury: \_\_\_\_\_

**PATIENT'S PERSONAL INFORMATION**      Marital Status:  Single  Married  Divorced  Widowed      Sex:  Male  Female

Name: \_\_\_\_\_

Street address: \_\_\_\_\_ (Apt # \_\_\_\_\_) City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_      Driver's License: (State & Number) \_\_\_\_\_

Employer / Name of School \_\_\_\_\_  Full Time  Part Time

Spouse's Name: \_\_\_\_\_ Spouse's Work phone: (\_\_\_\_) \_\_\_\_\_

How do you wish to be addressed? \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**PATIENT'S / RESPONSIBLE PARTY INFORMATION**

Responsible party: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Other \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Responsible party's home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ (Apt # \_\_\_\_\_) City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer's name: \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Your occupation: \_\_\_\_\_

Spouse's Employer's name: \_\_\_\_\_ Spouse's Work phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PATIENT'S INSURANCE INFORMATION**      Please present insurance cards to receptionist.

PRIMARY insurance company's name: \_\_\_\_\_

Insurance address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to insured:  Self  Spouse  Other  Child

Insurance ID number: \_\_\_\_\_ Group number: \_\_\_\_\_

SECONDARY insurance company's name: \_\_\_\_\_

Insurance address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to insured:  Self  Spouse  Other  Child

Insurance ID number: \_\_\_\_\_ Group number: \_\_\_\_\_

Check if appropriate:  Medigap policy  Retiree coverage

**PATIENT'S REFERRAL INFORMATION** (please circle one)

Referred by: \_\_\_\_\_ If referred by a friend, may we thank her or him? YES NO

Name(s) of other physician(s) who care for you: \_\_\_\_\_

**EMERGENCY CONTACT**

Name of person not living with you: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number (home): (\_\_\_\_) \_\_\_\_\_ Phone number (work): (\_\_\_\_) \_\_\_\_\_

### Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Medical Arts Family Practice, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Date: \_\_\_\_\_ Your Signature: \_\_\_\_\_

Method of Payment:  Cash  Check  Credit Card