NEW PATIENT REGISTRATION FORM

Patient Name: _____
Address: _____
_____
_____

Email Address: _____
Social Sec #: _____
Birth Date: _____
Sex: ___Male ___Female
Race/Ethnicity: ___White ___Black ___Am.Indian/Eskimo/Aleut ___Hispanic ___Not Hispanic/Latino
___Asain/Pacific Islander ___Unknown, Patient Refused
Preferred Language: ___English ___Spanish
Marital Status: ___Single ___Married ___Divorced ___Widowed
Home Ph#:
CellPh#: _____WorkPh#: _____
Employer :_____ Occupation: _____

Emergency Contact:_____ Relationship: _____
Home Phone: (_____) _____ Work Phone: (_____) _____

Responsible Party or Bill To Information:
Full Name: _____ Relationship:_____
Address: _____
City:_____ State: _____ Zip:_____
Home Phone: (_____) _____ Work Phone: (_____) _____
Birth Date: _____ Age: _____ Social Sec. #:_____
Employer: _____

Assignment Of Benefits and Authorization To Release Medical Information

I request that payment of authorized benefits Medicare, Medicaid, and/or any Insurance Carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services.

Signature:_____ Date:_____
Medicare Patients Only: HIC #:_____ Medical Insurer: _____

I request payment of authorized Medical benefits be made to _____, and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed ot determine benefits payable for services from this provider.

Signature:_____ Date:_____

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER(S).

A copy of this signature is as valid as the original. _____
Signature/Date