PATIENT REGISTRATION

REV. 1/2019

PATIENT DEMOGRAPHIC INFORMATION

PATIENT NAME:_____ **DATE OF BIRTH:** _____
(FIRST) (MIDDLE) (LAST)

MAILING ADDRESS:_____
(STREET / PO BOX) (CITY) (STATE) (ZIP)

PHONE:_____/_____/_____
Circle the preferred Number: (HOME) (CELL) (WORK)

E-MAIL ADDRESS:_____ **SOCIAL SECURITY #**_____

PREFERRED METHOD OF CONTACT: (check one) Phone_____, Email_____, Postal Mail_____

GENDER: Male_____ Female_____ **MARITAL STATUS:** Single___ Married___ Widowed___ Divorced___

PATIENT EMPLOYER_____ **PHONE #**_____

FOR PATIENTS THAT ARE 18 YEARS OR OLDER HEALTH CARE PROXY: This is an individual appointed by you, your family or the court to make health care decisions for you, if you are unable to do so yourself. Do you have a Proxy? NO_____ YES_____
If yes, name of individual:_____

DO YOU HAVE A LIVING WILL OR ADVANCED DIRECTIVE: No _____ Yes____ If yes: copy provided _____

LIST SOMEONE TO CONTACT IN CASE OF AN EMERGENCY OR IF WE NEED TO REACH YOU:
Name:_____ Phone# _____

IF THE PATIENT IS UNDER THE AGE OF 18, PLEASE LIST BOTH PARENTS NAMES, ADDRESS , DATE OF BIRTH & PHONE NUMBER:

Father: _____ **Mother:**_____
_____ _____
_____ _____

PATIENT INSURANCE

IF PATIENT HAS ANY INSURANCE, MEDICARE OR MEDICAID THAT COVERS YOUR MEDICAL CARE, WE MUST MAKE A COPY OF THE CARD IN ORDER TO FILE YOUR CLAIMS. PLEASE GIVE CARD(S) TO RECEPTIONIST WHEN YOU RETURN THIS FORM. IF YOU ARE HERE DUE TO A MOTOR VEHICLE ACCIDENT OR A WORKER COMPENSATION CLAIM, PLEASE LET US KNOW.

POLICY HOLDER NAME: _____ **DATE OF BIRTH:** _____

POLICY HOLDER RELATION TO PATIENT: (CIRCLE ONE) SELF PARENT SPOUSE OTHER: _____

SOCIAL SECURITY NUMBER: _____

AUTHORIZATION FOR TREATMENT & BILLING

I HEREBY AUTHORIZE THE PERFORMANCE OF ANY MEDICAL OR SURGICAL PROCEDURES UNDER LOCAL ANESTHESIA WHICH MAY BE ADVISED OR RECOMMENDED AS I PRESENT FOR DIAGNOSIS AND TREATMENT AT M.M.A. I PERMIT THE CLINIC, PHYSICIAN, NURSE PRACTITIONER, EMPLOYEES, OTHER SPECIALIST CALLED BY THEM AND ALL OTHER PERSONS CARING FOR ME TO TREAT ME IN A WAY THEY JUDGE BENEFICIAL TO ME.

I HEREBY AUTHORIZE THE ATTENDING PHYSICIAN, NURSE PRACTITIONER OR ASSISTANT TO ASSIST WITH CERTAIN ASPECTS OF MY CARE. I UNDERSTAND THAT A NURSE PRACTITIONER IS NOT A PHYSICIAN AND MAY ONLY TREAT/ DIAGNOSE AN ILLNESS, INJURY OR MEDICAL CONDITION UNDER THE SUPERVISION/ DIRECTION OF A LICENSED PHYSICIAN. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME.

I REQUEST PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE ON MY BEHALF TO THE PROVIDERS RENDERING SERVICE TO ME. I AUTHORIZE THE HOLDER OF MEDICAL INFORMATION ABOUT ME OR MY DEPENDENTS BE RELEASED TO THE INSURANCE COMPANY AND INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES. A PHOTOCOPY OF THIS AGREEMENT IS TO BE CONSIDEDRED AS VALID.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY ANY INSURANCE COMPANY.

X **PATIENT / GUARDIAN / RESPONSIBLE PARTY SIGNATURE** _____ **DATE:** _____