

PLEASE PRINT

PATIENT REGISTRATION

FORM 1001-REV 12/03

TODAY'S DATE		PATIENT REGISTRATION		FORM 1001-REV 12/03	
PATIENT NUMBER		PLEASE COMPLETE ALL WHITE AREAS			
LAST NAME		FIRST NAME & INITIAL			
ADDRESS LINE 1					
ADDRESS LINE 2					
CITY		STATE	ZIP	E-MAIL ADDRESS	
HOME PHONE		CELL PHONE	PAGER NUMBER		
SEX	MARITAL STATUS (M/S)	DATE OF BIRTH	M.D. REQUESTING YOUR APPOINTMENT		
PATIENT'S S.S. NO.		IF NOT REFERRED BY PHYSICIAN, PLEASE CHECK ONE BOX BELOW <input type="checkbox"/> PATIENT <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> PROVIDER BOOK <input type="checkbox"/> OTHER			
PATIENT'S EMPLOYER					
EMPLOYER ADDRESS					
CITY		STATE	ZIP		
EMPLOYER PHONE		EXT.			
RESP. PARTY LAST NAME		FIRST NAME & INITIAL		RELATIONSHIP	
ADDRESS					
CITY		STATE	ZIP	E-MAIL ADDRESS	
HOME PHONE		CELL PHONE	PAGER NUMBER		
RESP. PARTY DATE OF BIRTH		RESPONSIBLE PARTY S.S. NO.			
RESP. PARTY EMPLOYER		EMPLOYER PHONE		EXT.	
EMPLOYER ADDRESS		EMPLOYER FAX #			
MEDICARE, MEDICAID OR INS. #1 NAME				INS. #1 CODE	
INSURANCE #1 ADDRESS				INS. #1 PHONE	
POLICYHOLDER LAST NAME		FIRST NAME	RELATIONSHIP	SEX	
CERTIFICATE #		DATE OF BIRTH	SS #	M/F	
		GROUP NO.	MEMBER NO.		
INSURANCE #2 NAME				INS. #2 CODE	
INSURANCE #2 ADDRESS				INS. #2 PHONE	
POLICYHOLDER LAST NAME		FIRST NAME	RELATIONSHIP	SEX	
CERTIFICATE #		DATE OF BIRTH	SS #	M/F	
		GROUP NO.	MEMBER NO.		
INSURANCE #3 NAME				INS. #3 CODE	
INSURANCE #3 ADDRESS				INS. #3 PHONE	
POLICYHOLDER LAST NAME		FIRST NAME	RELATIONSHIP	SEX	
CERTIFICATE #		DATE OF BIRTH	SS #	M/F	
		GROUP NO.	MEMBER NO.		
NAME		RELATIONSHIP			
DATE OF BIRTH		S.S. NO.			
EMPLOYER		WORK PHONE			
NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU		RELATIVE/FRIEND PHONE			

PATIENT INFORMATION

The person seeing the doctor.

GUARANTOR

Person responsible for all unpaid balances on this account.

INSURANCE

List all insurance for which you have a current card. List Medicare or Medicaid first.

Spouse, step-parent, significant other

YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM

over ->

H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of **NOTICE OF PRIVACY PRACTICES:**

INITIAL _____

DATE _____

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

INITIAL _____

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INS BENEFITS: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

INITIAL _____

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

INITIAL _____

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

INITIAL _____

PATIENT'S SIGNATURE _____

DATE _____

Parent/Guardian _____

DATE _____

ADVANCED DIRECTIVE

1. Do You Have A Living Will? Yes _____ No _____
A copy may be needed for your chart.
A Copy Was Received By This Office. Date _____

2. Have You Appointed A Health Care Representative? Yes _____ No _____ Read and Sign Below
I give my consent and authorization for this person or persons I list below to act as my Health Care Representative to receive any and all information from my medical records, or discuss any and all aspects of my medical care. I also give consent, and authorization for the person, or persons to be notified any time I have an appointment. I also understand that I may revoke this privilege at any time by submitting my request in writing to this office.
Name of your Health Care Representative _____ Date _____
Name of your Health Care Representative _____ Date _____
Signed By: _____ Date _____
Witnessed By: _____ Date _____

3. Have You Given Anyone Your Power Of Attorney? Yes _____ No _____ Please list below
A copy may be needed for your chart.
A Copy Was Received By This Office. Date _____
Name _____ Relationship _____ Date _____

Release of Protected Health Care Information Via Telephone To Answering Machine, Or Voice Mail

I give my consent and authorization for the Medical, or Billing Staff of my Physician's Office to leave protected Health Care information about me or for me on my answering machine or voice mail via the telephone at the number I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

Number _____

Initial _____