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PATIENT REGISTRATION FORM

Welcome to our Practice!

PATIENT INFORMATION (PLEASE PRINT) DATE: ___/____/_____

Patient's Name: _____ Date of Birth _____ Age _____
(Last, first, Initial)

Address: _____ City _____ State _____Zip_____

Home Tel: (_____) _____ Work Phone: (_____) _____ Ext. _____ Cell Ph. _____

E-mail: _____ SS #: _____ Driver's Lic. # _____

Marital Status : _____ Patient's Employment Status: _____ Student: _____

Patient's Employer Name _____ Add. _____ Tel._____

If under 18: _____ Add. _____ Tel: (_____) _____
(Parent/Guardian)

Spouse's Name: _____ D.O.B _____ SS # _____ Tel. _____

Spouse's Employer _____ Emp. Add: _____Work Tel. _____

Emergency Contact: _____ Tel #: (_____)_____
(Other than spouse)

Pharmacy Name: _____ Tel # (_____)_____ E-mail_____

Primary Physician: _____ Tel# (_____)_____Fax #_____

Primary Insurance &Policy Holder Information

Name of Insurance: _____ Tel # (_____) _____

Billing Address _____ Policy/ID # _____ Grp. # _____

Effect. Date: _____ Enrol. Date: _____ Renewal Date _____ Benefit Code_____

Subscriber's Name _____ D.O.B._____ SS # _____
(Last, First, Initial)

Relationship to Patient: Self / Spouse / Child / (circle one) other: _____

Secondary Insurance & Policy Holder Information

Name of Insurance: _____ Tel # (_____)_____

Policy / ID # _____ Group #: _____ Efc. Date _____ Benefit Code_____

Subscriber's Name _____ D.O.B. _____ SS #_____

Tertiary Insurance Name: _____ Policy #: _____ Grp. # _____

Medicare I/D Number: _____

Does your employer give you the option to choose your Health Insurance Company? If so, list the choices you are offered:
1_____2_____3_____

Reason for Visit:
□ Routine Visit □ Emergency □ Follow-Up □ Complaint

Mode of payment for Office Visit: □ Cash □ Check □ Visa / MasterCard □ other: _____

PLEASE READ!

Payment in full is expected when services are rendered unless other arrangements are made in advance, if referral is needed and not received at the time of service, you will be billed for services provided. If payment from insurance companies is not received in our office within 90 days, you may be responsible for contacting your insurance company to determine payment status. If you are unable to keep your appointment, please notify our office at least 24 hours in advance. This will allow us to offer that appointment to other patients. Missed appointments or appointments not cancelled with at least 24 hours' notice will be charged a no-show fee.

IF THERE ARE ANY CHANGES IN YOUR ADDRESS, PHONE NUMBER, INSURANCE INFORMATION, ETC. BETWEEN VISITS, PLEASE NOTIFY OUR OFFICE

ASSIGNMENT OF BENEFITS

Insured / Authorized Person's Signature: I authorize payment of medical benefits to the physician or supplier for services rendered. X _____ Date: _____

Patient (Parent / Guardian if minor)

RELEASE OF INFORMATION

Patient / Authorized Person's Signature: I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

X _____ Date: _____

MEDICARE * MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as the original.

X_____ Date: _____

Patient (Parent / Guardian if minor)

BLOOD TESTS

You may have all of your blood tests done at your Lab Centre, or your primary physician's office. However, if you choose to have it done in our office, there will be a fee for drawing the blood. Do not call the office for results. We will notify you of any abnormal results. Your lab requisition will have your insurance information for billing purposes. If you do not have insurance, they will bill you direct. For any questions regarding a boll you receive from the Lab, call their billing department:

Quest billing dept. 1-800-825-7320 Genpath 1-800-229-5527

Lab Corp billing dept. 1-800-631-5250

AGREEMENT

If I agree to undergo blood tests and cultures for screening, I will be financially responsible for the charges in case my insurance does not cover the above expenses. It is my responsibility to know what my insurance requires, and to meet those requirements. Whenever referrals are needed for any particular test it is also my responsibility to obtain it and present it to the place of service.

X _____ _____

Patient (Parent / Guardian if Minor) Date

- Items or services: G0101/Q0091/G0107
(Annual Exam, Collection of Pap smear, & Occult Blood)
- Because: Medicare only covers this service every 2 years.

PLEASE CHOOSE ONE OPTION. CHECH ONE BOX SIGN AND DATE YOUR CHOICE

Date: _____ Signature of Patient or person acting on patient's behalf X _____

Option 1. YES, I WANT TO RECEIVE THESE ITEMS OR SERVICES

Option 2. NO I HAVE DECIDED NOT TO RECEIVE THESE ITEMS OR SERVICES