



# PATIENT REGISTRATION FORM

Today's Date: \_\_\_\_\_

## Patient Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Sex:  Male  Female Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Patient Referred By: \_\_\_\_\_

Marital Status:  Single  Married  Other (widow,divorced,separated) Patient PCP: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_ Spouse's Employer Phone: \_\_\_\_\_

## Guardian Information (If Applicable):

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

## Emergency Contact Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

## Employer Information:

Employer Name: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## Guarantor Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

## Insurance Information:

Insurance Plan Name: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_ Policy ID Number: \_\_\_\_\_

Street Address for Claims: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Patient's Relationship to Policy Holder: \_\_\_\_\_ Policy Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder Last Name: \_\_\_\_\_ Policy Holder First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Policy Holder Sex:  Male  Female

Policy Holder Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Policy Holder SS#: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_ Policy Holder Employer Name: \_\_\_\_\_

Policy Holder Employer Address: \_\_\_\_\_ Policy Holder Employer Phone: \_\_\_\_\_

## Injury and Workman's Compensation Information:

Is Injury Related to:  Work  Auto Accident  Other Date of Injury: \_\_\_\_\_ Work Comp Claim #: \_\_\_\_\_

Case Manager/Adjuster Name: \_\_\_\_\_ Case Manager/Adjuster Phone Number: \_\_\_\_\_

**Please read each of the following statements carefully and sign as your authorization, understanding and agreement to each statement.**

**ASSIGNMENT AND RELEASE:** I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process this claim to my employer, prospective employer and/or insurance carrier.

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

**MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE:** I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by \_\_\_\_\_. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

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

**FINANCIAL OBLIGATION:** I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am fully responsible for any and all charges not covered by my insurance carrier. I understand that payment may be requested at the time of service or I may be billed for such services subsequently.

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

**CONSENT FOR TREATMENT:** I hereby authorize the physician, nurses, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

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

**ADVANCED DIRECTIVE:** Do you have an advance directive (living will/power of attorney)?

\_\_\_\_ Yes \_\_\_\_ No If yes, please provide a copy for our records.

**For Office Use Only:**

**New Patient**

- Registration Form
- Completed Signatures on Back of Registration Form
- Insurance Verification Form
- Copy of Patient Insurance Card
- Obtained Patient Signature on Encounter Form
- Copy of Picture ID of Patient
- Patient Rights and Responsibilities – Notification to Patient
- Advanced Directive Information Provided
- HIPAA Notice of Privacy Practices
- Patient Medical History Form
- Authorization/Referral Form
- Any Prior Medical Records, Lab Tests, X-rays Needed for Visit
- If Applicable, Notice of Hospital Based
- If Medicare, Medicare Secondary Payor Form
- If Workman's Compensation – State Required Forms
- Collected CoPay
- Collected or Notified Patient of Any Prior Balance Due
- If Applicable, ABN or Notice of Non-Coverage

**Registration Staff Confirmation Checklist Completed:**

- Registration Staff Member Initials: \_\_\_\_\_ Date: \_\_\_\_\_
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**Established Patient**

- Registration Form – Insure 1 Year Current (if not, follow New Pt Cklist)
- Verified Patient Demographic Information
- Insurance Verification
- Obtained Patient Signature On Encounter Form
- Reviewed Patient Insurance Card and Compared to Copy in Chart
- Copy of Insurance Card for Billing Staff or Update for Chart
- Confirmed Copy of Picture ID in Chart
- Patient Rights and Responsibilities – Notification to Patient
- HIPAA Notice of Privacy Practices – Insure 1 Year Current
- Request to Change Release of Confidential Medical Information Form
- Patient Medical History Form
- Authorization/Referral Form
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**Discharge Staff Confirmation Checklist Completed:**

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