PATIENT REGISTRATION FORM

(Please print clearly)

Last Name ______________________ MI ______ First Name ______________________

Date of Birth ______________________

Home Address ____
Street *City* *State* *Zip*

Mailing Address if different ____
Street *City* *State* *Zip*

Home Phone __________________ Work Phone __________________ Other/Cell Phone __________________

Gender: Male Female	**Marital Status:** Single Married Widowed Other:_________	**Are you a veteran?** Yes No
Race: White Black / African-American Asian American Indian / Alaskan Native Native Hawaiian Pacific Islander More than one race Other: _______	**Are You:** Hispanic/Latino Not Hispanic/Latino	**Primary Language:** English Spanish Other:_____________

We want to make sure that all of our patients get the best care possible. We would like you to tell us your ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care.

The only people who see this information are registration staff, administrators for the health center, and the people involved in quality improvement and oversight. The confidentiality of what you say is protected by law.

Employment Information:

Employer Name: ____

Employer Address ____
Street *City* *State* *Zip*

Responsible person: (if different from patient)

Last Name ______________________________ MI _____ First Name ___________________________________

Date of Birth ____________________________ Telephone # ____

Address____
Street *City* *State* *Zip*

Relationship to patient____

Person to contact in case of emergency:

Name ____ Telephone # ______________________

Relationship to patient ____

PRIMARY MEDICAL INSURANCE INFORMATION

Name of Insurance ____

Member ID number ____________________________________ Group # ___________________________

Name of Subscriber ____________________________________ Subscriber Date of Birth __________________

Employer ____

Relationship to Patient: □ Parent □ Spouse □ Partner □ Other

Address (if different from patient) ____
Street *City* *State* *Zip*

SECONDARY INSURANCE INFORMATION

Name of Insurance ____

Member ID number ____________________________________ Group # ___________________________

Name of Subscriber ____________________________________ Subscriber Date of Birth __________________

Employer ____

Relationship to Patient: □ Parent □ Spouse □ Partner □ Other

Address (if different from patient) ____
Street *City* *State* *Zip*

Authorization and Consent

1. I request care from Medical Clinic PC for treatment of my medical or mental health condition, and/or for the routine or intensive care of my newborn baby. This care may include medical tests, exams, or other treatments that are needed for my condition. I agree to this care.

Insurance and Payment Information:

Medical Clinic PC receives payment for patient care from insurance companies, Medicare, and/or other third party programs.

1. I agree to have my insurance company, Medicare, or other third party payment program make payments directly to Medical Clinic PC.
2. I agree to let my doctor(s) and/or the Medical Clinic PC submit claims and required treatment information to my insurance company, Medicare, or other third party payment program for my care, and receive payments directly.
3. I understand that I must pay all charges, co-payments, and deductibles that are not covered by my insurance company, Medicare, or third party payment program.

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ___________________________________(N*ame of Insurance Company*) and assign directly to Medical Clinic PC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions.

Signature of the patient (or person authorized to sign for patient) _____________________________________

Relationship to Patient ____________________________________ Date __________________________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. ________________________/Medical Clinic PC for any service furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature ____ Date____________________

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Authorized Staff Signature **Date**