

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

NAME: _____ SEX M F BIRTHDATE ____/____/____
SOCIAL SECURITY #: _____ MARITAL STATUS: SINGLE () MARRIED () DIVORCED () WIDOWED ()
ADDRESS _____
(Street) (City) (State) (Zip)
HOME PHONE ____ (____) _____ OCCUPATION _____
EMPLOYER _____ WORK PHONE ____ (____) _____
EMPLOYER ADDRESS: _____

SPOUSE OR PARENT INFORMATION:

NAME: _____ BIRTHDATE: _____ SOCIAL SECURITY #: _____
ADDRESS _____
HOME PHONE ____ (____) _____ OCCUPATION _____
EMPLOYER _____ WORK PHONE ____ (____) _____
EMPLOYER ADDRESS: _____

PRIMARY CARE PHYSICIAN INFORMATION:

PHYSICIAN NAME: _____ CITY _____ PHONE #: (____) _____

EMERGENCY CONTACT INFORMATION: (SOMEONE NOT LIVING WITH YOU)

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ PHONE #: (____) _____

PRIMARY HEALTH INSURANCE INFORMATION:

NAME OF COMPANY: _____ ADDRESS: _____
NAME OF PERSON CARRYING THE INSURANCE & RELATIONSHIP: _____
GROUP: _____ POLICY NUMBER: _____

SECONDARY HEALTH INSURANCE INFORMATION:

NAME OF COMPANY: _____ ADDRESS: _____
NAME OF PERSON CARRYING THE INSURANCE & RELATIONSHIP: _____
GROUP: _____ POLICY NUMBER: _____

COMPLETE THIS IF FILING FOR WORKMAN COMPENSATION / ACCIDENT INSURANCE:

ACCIDENT INFO: Auto ____ Employment ____ Other ____ Date of Accident _____ Health Ins ____ Work Comp ____ Auto Ins ____
NAME: _____ ADDRESS _____ CLAIM #: _____

AUTHORIZATION FOR RELEASE OF INFORMATION AND PAYMENT REQUEST:

I hereby authorize my attending physician to release my personal health information to my insurance company and for my insurance company to pay directly to this facility, my attending physician all benefits otherwise payable to me, but not to exceed the regular charges for the period of hospitalization and / or treatment beginning on this admission.

ACKNOWLEDGMENT OF NOTIFICATION OF PRIVACY PRACTICE

I acknowledge that I had read and have the opportunity to see the notice of privacy practice.

USUAL AND CUSTOMARY RATES:

We charge what is reasonable and customary for our area. We file claims as a courtesy to our patients based on the insurance information you provide us. If you provide us incomplete information that lead to delay filing of your claim and subsequent denial of payment from your insurance due to late filing, you may be held responsible for the amount.

If we are a **contracted provider** with your insurance companies, we are responsible to collect any applicable Copayments, Coinsurance, or Deductibles specified in your policy, with exception of cosmetic services. You will be responsible for all payments of cosmetic, non-health related services provided as they are typically NON-COVERED services by insurances.

If we are **not a contracted provider** with your insurance companies, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, etc., other than to provide factual information as necessary. You will be responsible for all payments of cosmetic, non-health related services provided as they are typically NON-COVERED services by insurances.

I HAVE READ AND UNDERSTAND THE ABOVE: **PATIENT SIGNATURE:** _____ **DATE:** _____