PATIENT REGISTRATION *(Please Print)*

PATIENT INFORMATION

PATIENT NAME _____

BIRTHDATE _____ (MM / DD / YY) AGE _____ SOC. SEC. # _____ ☐ MALE ☐ FEMALE

RESPONSIBLE PARTY (if other than patient) _____ (Name) _____ (Date of Birth) _____ (Relationship)

MAILING ADDRESS _____ (Street) APT # _____

_____ (City) _____ (State) _____ (Zip) - _____ (+4) _____ (Social Security Number)

HOME PHONE ( ) _____ - _____ WORK PHONE ( ) _____ - _____ EMPLOYER _____

REFERRED BY _____ PRIMARY CARE DR _____

MARITAL STATUS: ☐ SINGLE 1 ☐ MARRIED 2 ☐ WIDOWED 4 ☐ DIVORCED 5 ☐ SEPARATED 6 ☐ OTHER 3

IF INJURED: _____ (Date) _____ (Cause) ☐ WORK ☐ AUTO _____ (Claim #)

INSURANCE INFORMATION

PATIENT'S EMPLOYER _____ SPOUSE'S NAME _____

OCCUPATION _____ SPOUSE'S EMPLOYER _____

ADDRESS _____ OCCUPATION _____

CITY, STATE, ZIP _____ HOME PHONE _____ WORK PHONE _____

PRIMARY INSURANCE _____ PLAN COPAY $ _____

_____ (Subscriber Name) ☐ MALE ☐ FEMALE BIRTHDATE _____

_____ (Social Security Number) _____ (Relationship to Patient)

_____ (Subscribers Employer) _____ (Insurance Company Address)

SUBSCRIBER ID # _____ GROUP ID # _____

SECONDARY INSURANCE _____ PLAN COPAY $ _____

_____ (Subscriber Name) ☐ MALE ☐ FEMALE BIRTHDATE _____

_____ (Social Security Number) _____ (Relationship to Patient)

_____ (Subscribers Employer) _____ (Insurance Company Address)

SUBSCRIBER ID # _____ GROUP ID # _____

EMERGENCY INFORMATION

IN CASE OF EMERGENCY NOTIFY _____ (Name) ( ) _____ (Home Phone)

_____ (Relationship to Patient) ( ) _____ (Work Phone)

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to the healthcare provider as well as release of any information by provider or insurance company required for this account. Release of information to include: (1) alcohol and / or drug abuse treatment, (2) psychiatric diagnosis, treatment and summaries, (3) test results for HIV (Human Immunodeficiency Virus), STD (Sexually Transmitted Diseases), and (4) Treatment of HIV, STDs, AIDS (Acquired Immunodeficiency Syndrome) and related conditions. I hereby release PrimeCare from all legal responsibility or liability that may arise from disclosure of my record as provided by this paragraph.

Payment: I am financially responsible for any balance due. I agree to make payment arrangements; pay $5 or 1% interest per month (whichever is greater) on unpaid balances over 30 days and all the reasonable expenses such as attorney fees and court costs should account be referred for collections.

_____ **SIGNED** **DATE**

I'VE VERIFIED THAT MY PATIENT DEMOGRAPHICS ARE THE SAME.

_____ **SIGNED** **DATE**