Patient Registration

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)** All information will be strictly confidential.

Patient's Name	Sex M F	Birth Date ____/____/_____ Age_____	Marital Status Single **[ ]** Married **[ ]** Widowed **[ ]** Divorced **[ ]**
Residence address City State Zip		Home Phone:	Patient's SS #
Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birthdate ____/____/_____	Responsible Party's SS #
E-mail address			
Name of employer Address		Business Phone	Occupation
Name of Spouse/Parent	Spouse/Parent Birthdate ____/____/_____	Spouse/Parent SS #	Business phone
Reason for Visit:	Referred by: (include address and phone)		
Person to contact in case of emergency:	Relationship to patient		Phone

Medicare Yes **[ ]** No **[ ]**	Medicare #	Medicaid Yes **[ ]** No **[ ]**	Medicaid #	Effective Date
Medicare Secondary insurance name Address			Policy #	Group #

Workers' Compensation? Yes **[ ]** No **[ ]** Motor Vehicle? Yes **[ ]** No **[ ]** **If Yes-put W/C or MVA carrier below**	Date of Accident	Claim #	Case Worker's Name	W/C or MVA Insurance Phone #
Primary insurance company Address				Insurance Phone #
Subscriber Name	Subscriber birth date		Policy #	Group #
Secondary insurance name Address			Policy #	Group #

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Practice Name for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services

_____ _____

Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Practice Name for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

I authorize Advantage and/or our agents to contact me by telephone at any number associated with my account, including wireless telephone to collect monies I may owe. Methods of contact may include pre-recorded/artificial voice messages and the use of automatic dialing device, as applicable.

_____ _____

Patient, Parent or Guardian Signature Date