

# 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:
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 [ ]	Date of Accident	Claim #	Case Worker's Name		W/C or MVA Insurance Phone #
Primary insurance company					Address	
Subscriber Name					Subscriber birth date	
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