

# PATIENT REGISTRATION FORM

Please print clearly and complete **each** section. Present your **driver's license** and **insurance card(s)** when returning this form to the receptionist.

## SECTION A: PATIENT INFORMATION

Today's Date:	Social Security #:	Patient's Name:								
		First name	Middle initial	Last name						
Sex: (please circle) M or F	Date of Birth:	Marital Status: (please circle) Single Married Divorced Widowed Separated								
Employer's Name & Address:		Occupation:								
Home mailing address:		City:	State:	Zip:						
Home Phone Number: ( )	Work Phone Number: ( )	Cell Phone Number: ( )								
If Under Age 18; Parent or Guardian Name:		Preferred Pharmacy Name _____ City _____								
Please let us know how you found us: (please circle) Newspaper _____ Drive by or sign _____ Insurance directory _____ Friend or Relative _____ Yellow pages/phone book _____		Please designate to whom we may release or discuss any of your medical records or information concerning your health: Changes must be submitted in writing.  <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; border-bottom: 1px solid black;">name</td> <td style="width: 30%; border-bottom: 1px solid black;">phone number</td> <td style="width: 40%; border-bottom: 1px solid black;">relationship</td> </tr> <tr> <td style="border-bottom: 1px solid black;">name</td> <td style="border-bottom: 1px solid black;">phone number</td> <td style="border-bottom: 1px solid black;">relationship</td> </tr> </table>			name	phone number	relationship	name	phone number	relationship
name	phone number	relationship								
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## SECTION B: BILLING & INSURANCE INFORMATION

Person Responsible for Bills:		Patient's Relationship to Responsible Party:		
Billing Address:		Phone #:		
Primary Insurance Carrier:	Group #:	ID #:		
Subscriber's name:	Subscriber's Date of Birth:	Subscriber's Social Security #:		
Patient's Relationship to Subscriber: (Please Circle):    Self    Wife    Husband    Child    Other (Specify)				
Secondary Insurance Carrier:		Group #:	ID #:	
Subscriber's name:	Subscriber's Date of Birth:	Subscriber's Social Security #:		
Patient's Relationship to Subscriber: (Please Circle):    Self    Wife    Husband    Child    Other (Specify)				

## SECTION C: PATIENT'S ACKNOWLEDGEMENT OF NPP

I have received Urgentmed's Notice of Privacy Practices (NPP). This office reserves the right to change the terms of its NPP and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current NPP on request.

✓ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## SECTION D: ASSIGNMENT AND RELEASE

I hereby give consent to Urgentmed, P.C., its employees, and medical trainees for examination and treatment. I request that payment of authorized benefits be made on my behalf to Urgentmed, P.C. for any services rendered to me by their physicians and staff. I further authorize release of my medical records to my insurance carrier, and/or their billing company or third party administrator as needed to determine these benefits. I authorize the use of this signature on all insurance submissions. I agree that I am financially responsible for all charges of services rendered, medications, or supplies provided by Urgentmed, P.C. on my behalf or my dependents. I agree that I am responsible for late fees of 1.5% per month of my account balance if payment is not received within 60 days. In addition, I am responsible for a \$50.00 administrative fee as well as collection fees of 50% of my account balance if my account proceeds to a collection company after 90 days, and court & legal fees up to \$1500.00 if this practice needs to hire an attorney and proceed to small claims court.

✓ Signature: \_\_\_\_\_ Date: \_\_\_\_\_