

# Patient Registration

Medi-Claim 2009

Date \_\_\_\_\_ PLEASE PRINT LEGIBLY AND COMPLETE ALL APPLICABLE SECTIONS

PATIENT				FINANCIALLY RESPONSIBLE PARTY			
<input type="checkbox"/> NEW PATIENT		<input type="checkbox"/> CHANGE OF INFORMATION		<input type="checkbox"/> If same as Patient, please check here and skip this section			
First Name	MI	Last Name		First Name	MI	Last Name	
Gender <input type="checkbox"/> F <input type="checkbox"/> M		SSN	DOB	Gender <input type="checkbox"/> F <input type="checkbox"/> M		SSN	DOB
Home Address				Billing Address			
City	St	Zip		City	St	Zip	
Home Phone ( )		Cell Phone ( )		Home Phone ( )		Cell Phone ( )	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed				Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian/Conservator			
Employer Name				Employer Name			
Employer Address				Employer Address			
City	St	Zip		City	St	Zip	
Work Phone ( )		Extension		Work Phone ( )		Extension	
Emergency Contact Name and Relationship				Emergency Phone No(s)			
Primary Care Physician Name and Phone No				Who may we thank for referring you to this office?			

SUBSCRIBER 1				SUBSCRIBER 2			
<input type="checkbox"/> If same as Patient, please check here and skip to COVERAGE				<input type="checkbox"/> If same as Patient, please check here and skip to COVERAGE			
First Name	MI	Last Name		First Name	MI	Last Name	
Gender <input type="checkbox"/> F <input type="checkbox"/> M		SSN	DOB	Gender <input type="checkbox"/> F <input type="checkbox"/> M		SSN	DOB
Address				Address			
City	St	Zip		City	St	Zip	
Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian/Conservator				Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian/Conservator			
COVERAGE (Copy of card is REQUIRED)				COVERAGE (Copy of card is REQUIRED)			
ID No		Group No		ID No		Group No	
Insurance Co Name				Insurance Co Name			
Claim Address				Claim Address			
City	St	Zip		City	St	Zip	
Phone ( )		Extension		Phone ( )		Extension	

I certify that to the best of my knowledge the above information is correct. I authorize that all applicable insurance benefits to be paid directly to the provider.  
 I understand that I am financially responsible for any deductibles, co-payments and co-insurances, and any other reasonable charges not under my insurance coverage.  
 I authorize this office and its authorized agents to release limited medical information required to process insurance claims.

\_\_\_\_\_  
Signature of Patient/Guardian/Financially Responsible Party

\_\_\_\_\_  
Date