PATIENT INSURANCE REGISTRATION FORM

PATIENT'S NAME _____ SOCIAL SECURITY #_____
(Last, First, Middle Initial)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE (Home) _____ PHONE (Daytime) _____ PHONE (Cell) _____

EMAIL: _____ DATE OF BIRTH_____ SEX (circle): MALE FEMALE MARITAL STATUS (circle): S / M / D / W

***THE FOLLOWING MUST BE INDICATED SINCE THEY ARE GOVERNMENT MANDATED QUESTIONS**
***RACE (circle): AMERICAN INDIAN/ALASKA NATIVE ASIAN BLACK /AFRICAN AMERICAN NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER WHITE**
***ETHNICITY (circle): HISPANIC NON-HISPANIC PREFERRED LANGUAGE:**

PRIMARY CARE PHYSICIAN NAME:_____ PHONE#_____
(as stated on insurance card if applicable)

EMPLOYER NAME: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE'S NAME _____ SPOUSE'S PHONE _____ SPOUSE'S DATE OF BIRTH_____

SPOUSE'S ADDRESS _____ CITY _____ STATE_____ ZIP_____

RESPONSIBLE PARTY INFORMATION (circle) SELF SPOUSE CHILD PARENT STUDENT OTHER **IF NOT SELF, COMPLETE FIELDS BELOW;**

NAME (Last, First)_____ TELEPHONE_____

ADDRESS_____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT:_____ PHONE: _____ CELL: _____

RELATIONSHIP TO PATIENT_____ ADDRESS OF CONTACT_____

INSURANCE INFORMATION (Please write information about the patient's insurance here.)

PRIMARY INSURANCE CO. NAME_____ SECONDARY INSURANCE CO. NAME_____

INSURED'S ID NO._____ INSURED'S ID NO._____

GROUP PLAN NO._____ GROUP PLAN NO._____

INSURANCE CO. ADDRESS_____ INSURANCE CO. ADDRESS_____

RELATIONSHIP TO INSURED_____ RELATIONSHIP TO INSURED_____

NAME OF INSURED_____ NAME OF INSURED_____

ADDRESS OF INSURED_____ ADDRESS OF INSURED_____

D.O.B. OF INSURED_____ SEX OF INSURED_____ D.O.B. OF INSURED_____ SEX OF INSURED_____

PHARMACY NAME:_____ ADDRESS_____

PHONE NUMBER:_____ PHARMACY FAX:_____

HOW WERE YOU REFERRED TO OUR OFFICE?(circle):SELF/ANOTHER PATIENT/WINTHROP EMERGENCY ROOM/EMPLOYER/DOCTOR/OTHER (please explain)

IF REFERRED BY OTHER, PLEASE EXPLAIN: _____

IF REFERRED BY A DOCTOR; PHYSICIAN NAME:_____ PHONE# _____

IF CLAIM IS NO FAULT OR WORKERS COMPENSATION PLEASE NOTIFY THE RECEPTIONIST FOR THE APPROPRIATE FORMS...

DID INJURY OCCUR AT SCHOOL? (circle):YES NO **WAS INJURY DURING A SCHOOL SPORT**(circle):YES NO **NAME OF SPORT:** _____

DATE OF INJURY: _____ SCHOOL NAME:_____ SCHOOL PHONE#:_____

SCHOOL INSURANCE CARRIER NAME: _____

SCHOOL INSURANCE ADDRESS: _____ CITY, STATE & ZIP:_____

X_____ _____

PATIENT (or authorized signature) DATE

PATIENT RESPONSIBILITY FORM

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**
   - I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
   - Co-payments are due at time of service.
   - If my plan requires a referral, I must obtain it prior to my visit.
   - In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
   - If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**
   I hereby authorize and direct payment of my medical benefits to (PROVIDER OR GROUP NAME) on my behalf for any services furnished to me by the providers.

3. **AUTHORIZATION TO RELEASE RECORDS**
   I hereby authorize (PROVIDER OR GROUP NAME) to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. **MEDICARE REQUEST FOR PAYMENT**
   I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (PROVIDER OR GROUP NAME). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party | Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party | Relationship to Patient