CHART #______________________

NEW PATIENT REGISTRATION FORM FOR PROVIDER______________________

Patient Name: ______________________________

Address: ______________________________

____

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E-mail Address: ______________________________

Social Sec #: ____________________ Sex: __Male __Female

Birth Date: ____________ Age: ________

Marital Status: __Single __Married __Divorced __Widowed

Home Phone: ____________________ **Work Phone:** ____________________

Cell Phone: ________________ Preferred Phone Number ____________________

Ethnicity: __ Hispanic or Latino **Preferred Language:** __ English

__ Not Hispanic or Latino __ Spanish

Race: __White __ Black __ Am Indian/Eskimo __ Hispanic __ Asian/Pacific Islander __ Other

Employer :______________________________ **Occupation:** ____________________

Employer Address:______________________________

____

Emergency Contact:____________________________ **Relationship:** ______________

Home Phone: (_____) ____________________ **Work Phone:** (_____) ____________________

Who is financially responsible for payment of these services?

__Self __Spouse __Parent/Guardian __Workers Comp Other: ____________________

Responsible Party or Bill To Information:

Full Name: ______________________________ Relationship:______________

Address: ______________________________

City:______________________________ State: ____________ Zip:____________

Home Phone: (_____) ____________________ Work Phone: (_____) ____________________

Cell Phone: (_____) ____________________ E-mail address: ____________________

Birth Date: ____________ Social Sec. #:____________________

Employer: ______________________________

Employer Address : ______________________________

Assignment Of Benefits and Authorization To Release Medical Information

I request that payment of authorized benefits Medicare, Medicaid, and/or any Insurance Carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services.

Signature:______________________________ Date:____________________

Medicare Patients Only: HIC #:____________________ Medical Insurer: ____________________

I request payment of authorized Medical benefits be made to the above listed provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

Signature:______________________________ Date:____________________