PATIENT REGISTRATION

Please take the time to fill in all the blank spaces.

PATIENT INFORMATION

PATIENT'S LAST NAME			FIRST		MIDDLE
AGE	BIRTHDATE / /	SEX	SOCIAL SECURITY NUMBER - -		HOME/CELL PHONE
PATIENT'S MAILING ADDRESS			EMPLOYER		
CITY	STATE	ZIP	OCCUPATION		BUSINESS PHONE
SPOUSE'S NAME			EMPLOYER ADDRESS		
SPOUSE'S EMPLOYER	BUSINESS PHONE		CITY	STATE	ZIP

WHO SHOULD BE NOTIFIED OTHER THAN HUSBAND OR WIFE IN CASE OF AN EMERGENCY?

NAME	PHONE NUMBER	RELATIONSHIP

RESPONSIBLE PARTY: RESPONSIBLE FOR OBTAINING CURRENT AND UPDATED REFERRALS FROM FAMILY DOCTOR

FULL NAME		HOME/CELL PHONE	SOCIAL SECURITY NUMBER - -
ADDRESS		EMPLOYER	
CITY	STATE / ZIP	OCCUPATION	BUSINESS PHONE

INSURANCE INFORMATION– Please present your insurance card to the receptionist today

Primary Insurance Plan: _____

Group Number: _____ ID Number: _____

Subscriber's Name: _____ D.O.B. _____ Employer: _____

Secondary Insurance Plan: _____

Group Number: _____ ID Number: _____

Subscriber's Name: _____ D.O.B. _____ Employer: _____

Name of Referring Physician: _____

IF DUE TO AN INJURY:

Date of Injury: _____ Time: _____ Where: _____

How did this happen? _____

Is this due to an On the Job Injury? YES / NO If yes, Name of Employer at Time of Accident: _____

Is there an Attorney Representing your injury? YES / NO If auto accident, what state? _____

Name of Attorney: _____ Phone Number: _____

[ ] I HAVE NO INSURANCE COVERAGE—PLEASE BILL ME DIRECT.

Signature: _____

PLEASE SIGN THE INSURANCE PAYMENT AUTHORIZATION ON THE BACK OF THIS SHEET

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize medical care for _____. I hereby authorize my insurance benefits be paid directly to the physician. I understand I am financially responsible for payment of all services according to Pyramid Health Center policy, regardless of any pending insurance claims. I authorize the physician to release any information necessary to the insurance company (ies) as listed above for the processing of claims.

I understand that my express consent is required for the medical provider to release any information in relation to the diagnosis and/or treatment of HIV (Aids virus), sexually transmitted disease, drug or alcohol abuse, psychiatric treatment or mental illness. If I have been treated or diagnosed in connection with any of the above listed conditions, you are specifically authorized to release to the above listed insurances all information or medical records relating to the diagnosis, testing or treatment *

Client assumes all responsibility for Collection fees, Collections costs, Attorney fees and Court costs.

Patient Signature: _____ Date: _____

If a minor, by parent or guardian: _____ Date: _____

*If the patient has reached his/her 14th birthday, ONLY the patient may authorize disclosure relating to sexually transmitted disease.

MEDICARE AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical or other information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information necessary for this or a related Medicare / Medigap / other insurance claim.

I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

Regulations pertaining to Medicare assignment of benefits apply. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Regulations pertaining to Medicare assignment of benefits also apply.

Patient Signature: _____ Date: _____

PRIVACY POLICY

Patient Signature: _____ Date: _____