

PATIENT REGISTRATION FORM

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PATIENT INFORMATION	Patient Information		Is this a work related incident?		YES	NO	Motor Vehicle Accident?		YES	NO	
	Last Name:			First Name:			M.I.:		Previous Name (if applicable)		
	Mailing Address:						Apt #				
	City/State/Zip:										
	Home Phone:			Cell Phone:			Work Phone:				
	Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) <input type="checkbox"/> Voice <input type="checkbox"/> Text						If Voice, Please Select Preferred Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work				
	Family Physician or Pediatrician:				Date of Birth:				Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
	Marital Status:				Social Security #:						
	Employer Name:				Emergency Contact Name:						
	Emergency Contact Phone #:						Relationship to Patient:				
Additional Information and Responsible Party	Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor										
	Last Name:					First Name:					
	Date of Birth:			Social Security #:				Phone:			
	Address of Person Responsible:										
	City/State/Zip:					Relationship to Patient:					
	Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)										
	Email Address:						Can we leave a message regarding your medical care & test results? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Race (please select): <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Decline						Ethnicity (please select one): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline				
	Preferred Language (please select one):			<input type="checkbox"/> English		<input type="checkbox"/> Bosnian		<input type="checkbox"/> Indian (including Hindi & Tamil)			
				<input type="checkbox"/> Sign Language		<input type="checkbox"/> Spanish		<input type="checkbox"/> Russian <input type="checkbox"/> Other			
Preferred Pharmacy Name & Location:											
Insurance Information	Primary Medical Insurance					Secondary Medical Insurance					
	Ins. Co. Name					Ins. Co. Name					
	Policy Holder Name:					Policy Holder Name:					
	Policy Holder's Date of Birth:					Policy Holder's Date of Birth:					
	Policy Holder's Social Security #:					Policy Holder's Social Security #:					
	Patient Relationship to Policy Holder:					Patient Relationship to Policy Holder:					
<p>ALL INSURANCE AND SELF PAY PATIENTS: ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT'S ACCOUNT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIERS PAYMENTS; HOWEVER, IF INSURANCE IS DENIED OR INSURANCE INFORMATION IS NOT RECEIVED AT THE TIME OF SERVICE THE PATIENT/ GUARDIAN IS RESPONSIBLE FOR ALL APPLICABLE FEES. IT IS CUSTOMARY TO PAY APPLICABLE CO- PAY/CHARGES WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE MANAGER.</p> <p>If visit is to be submitted to an insurance company, please read and initial the following: I request that payment of authorized Medicare/ or other Insurance Carrier of benefits be made either to me or on my behalf to Treasure Coast Urgent and Family Care for any services furnished to me by that party. Regulations pertaining to Medicare assignment of benefits apply.</p> <p>I authorize any holder of medical or other information about me, to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare/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 the assignment. 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.C3801-3212 provides penalties for withholding this information)</p>											

I have reviewed and understand the above insurance information: _____ (Initials)

Signature of Responsible Party: X _____ Date: _____

Printed Name of Responsible Party: X _____ Date: _____