Patient Registration

Doctor:____________________________ Internal Patient ID #:_________

PATIENT INFORMATION

Name: ____

Address:____

____

City/State/Zip:____

Phone: ______________________________ ☞Home ☞Work ☞Other

Phone: ______________________________ ☞Home ☞Work ☞Other

Sex: ☞M ☞F

Date of Birth: ____

Social Security #: _____________________________________

Marital Status: ☞Married ☞Single ☞Divorced ☞Widowed

Referring Physician: ___________________________________

Primary Physician: _____________________________________

PATIENT EMPLOYMENT

☞Employed ☞Retired ☞Other

Phone:____

Employer:____

CONTACTS

____

____

____

GUARANTOR- Responsible Party-who carries the Insurance

☞Same as Patient ____

Name: ____

Address:____

____

City/State/Zip:____

GUARANTOR'S EMPLOYMENT INFORMATION

Employer:____

Phone:____

Phone:____

Social Security#:____________________________________

Date of Birth: _______________________________________

PRIMARY INSURANCE

☞Same as Patient ☞Same as Guarantor ☞Other

Insured Party: ____

Insured Phone:____

Insurance Company: ____

Relationship to Patient: ________________________________

Insured's Social Security #: ____________________________

Insured ID: ____

Policy Group:____

Insured's Date of Birth: _________________________________

SECONDARY INSURANCE

☞Same as Patient ☞Same as Guarantor ☞Other

Insured Party: ____

Insured Phone:____

Insurance Company: ____

Relationship to Patient: ________________________________

Insured's Social Security #: ____________________________

Insured ID: ____

Policy Group:____

Insured's Date of Birth: _________________________________

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to the attending physician. The assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not said insurance company pays. I hereby authorize said assigned to release all information necessary to secure payment.

Signed:____ Date:________________________________

The Medical and Surgical Clinic of Irving