Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ **(First)** _____ **(MI)** _____ **Previous Name** _____

Address Line 1 _____

City, State _____ **ZIP**_____

Pharmacy_____ **Pharmacy Address**_____**Pharmacy Phone**_____

Home Phone _____ **Cell No.** _____ **Work Phone** _____**Ext.** _____

Primary Care Doctor_____ **Address**_____ **Phone**_____

Referring Doctor _____ **Address**_____ **Phone**_____

Doctor you are seeing at this facility? _____ **E-Mail Address**_____

Date of Birth MM _____/DD _____/YYYY _____ **Sex** ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ **Employer Name** _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Do you have a living will? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Last Name _____ First Name _____

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____

City, State _____ ZIP_____ Home Phone_____

Cell Phone _____ Work Phone _____ Ext. _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Auto related? ☐ **Yes** ☐ **No** (If yes, please see receptionist for additional form)

Work related? ☐ **Yes** ☐ **No** (If yes, please see receptionist for additional form)

Insurance Company/Phone Number_____ (_____)_____

Name of Policy Holder:_____ Patient Relationship to policy Holder:_____

Social Security Number of Policy Holder_____Date of Birth MM __/DD_____/YYYY _____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____ (_____)_____

Name of Policy Holder:_____ Patient Relationship to policy Holder:_____

Social Security Number of Policy Holder:_____Date of Birth MM __/DD_____/YYYY _____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance; however you are responsible for your co-pay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physicians when required. If the referral is not obtained before the visit, the patient is liable for time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable. I_____ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

_____ _____

Signature Date

I authorize this facility to release information to (Please check all that apply and list complete name and phone numbers)

☐Spouse :_____

☐Children :_____

☐Other :_____

☐No One

_____ _____

Signature Date

Medicare Patients

I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for any services furnished me by the provider. I authorize any holder of medical information about me; to release Medigap Insurer _____ any information needed to determine those benefits payable for related services.

_____ _____

Signature Date

Medicare Lifetime Authorization

HIC#_____

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct and authorize any holder of the medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians' services to the physician or organization furnishing the services or authorized such physician or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurances.

Signed :_____ Date :_____

Print Name :_____Title or relationship :_____

Witnessed by :_____Address :_____

If signed by other than beneficiary, state reason the patient was unable to sign :_____