

You may print and fill out our Patient Registration Record & One Time Authorization Forms.
Please bring this with you to your first appointment.



Patient Registration Record

Referring Physician _____

Primary Care Physician _____

Patient

First Name _____ Middle Initial _____

Last Name _____

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____

Email _____ Cell Phone _____

Social Security Number _____

Employer _____

Occupation _____

Sex _____ Marital Status _____

Birthdate _____ Age _____

Responsible Party

First Name _____ Middle Initial _____

Last Name _____

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____

Email _____ Cell Phone _____

Social Security Number _____

Employer _____

Occupation _____

Sex _____ Marital Status _____

Birthdate _____ Age _____

Relationship to Responsible Party:

Self Spouse Child Other _____

Name, address and phone of person not living with you and their relationship to you, to contact in case of emergency. _____

If retired, date of retirement _____

Insurance Information

Primary Insurance Co. and Address _____

Name of Insured Person _____

Insurance I.D. No. _____

Relationship of Patient to Insured _____

Secondary Insurance Co. and Address _____

Name Insured Person _____

Insurance I.D. No. _____

Relationship of Patient to Insured _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby assign payment directly to the undersigned physician for surgical and/or medical benefits. I understand I am financially responsible for charges not covered by my insurance.

Signed Date

FINANCIAL RESPONSIBILITY: I hereby acknowledge that I accept full responsibility for any medical service rendered to me or anyone for whom I am legally responsible, subject to contractual agreements through the patient and/or signer's coverage.

Signed Date



ONE TIME AUTHORIZATION

NAME OF BENEFICIARY _____

HI CLAIM NUMBER _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

DO NOT MAIL THIS FORM IN – Retain in Patient’s File in Your Office

Patient’s Signature

Date Signed

**MEDICARE SECONDARY PAYER QUESTIONNAIRE
(TO BE COMPLETED FOR ALL MEDICARE PATIENTS)**

NAME: _____

DATE OF SERVICE: _____

(If any answer to questions 1a. through 4. is yes, the corresponding section of the “Other Insurance” form must be filled out completely.)

- | | YES | NO |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|
| 1. Is the Patient a Veteran? | _____ | _____ |
| a. Did the VA refer you here for treatment? | _____ | _____ |
| b. Does the patient have a VA “fee basis ID Card?” | _____ | _____ |
| 2. Do you have a Federal Black Lung card? | _____ | _____ |
| 3. Is this medical condition due to an accident of any kind? | _____ | _____ |
| If yes was it: Work Related <input type="checkbox"/> Auto <input type="checkbox"/> Injured in Own Home <input type="checkbox"/> Other <input type="checkbox"/> | | |
| 4. Is the patient covered by an employer’s health insurance plan through their own employment or that of a family member? | _____ | _____ |