

# Patient Registration Form



Patient Information	Last Name		First Name	M.I.	Previous Name( if applicable)	
	Mailing Address		Apt#	City	State	Zip
	Home Phone		Cell Phone	Work Phone w/ext		
	Preferred contact number: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell					
	Family Physician (PCP):			Birth Date	Sex	
	Marital Status:		Social Security Number			
In Case of Emergency	Name of emergency contact		Relationship to Patient			
	Address		Home Number		Work Number	
Insurance & Payment Information	Person responsible for the bill ( <b>ONLY IF DIFFERENT THAN THE INSURED</b> ):		Date of Birth	Social Security #	Phone:	
	Address of Person Responsible		Employer of Person Responsible			
	City, State Zip		Relationship to Patient			
	<b>Primary Medical Insurance</b>			<b>Secondary Medical Insurance</b>		
	Ins. Co. Name _____		Ins. Co. Name _____			
	Policyholder's name _____		Policyholder's name _____			
	Policyholder's address if not same. _____		Policyholder's address if not same. _____			
Policyholder Birth Date _____		Insured's Social # _____		Policyholder Birth Date _____		
Insured's Social # _____		Insured's Social # _____				
Patient Relationship to Insured _____		Patient Relationship to Insured _____				
Employer Name _____		Employer Name _____				
Additional Information	Physical Address (if different than mailing)		Apt#	City	State	Zip
	<b>Email Address:</b>		Can we leave info on your home answering machine regarding your medical care and test results? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	<b>VFC Eligibility:</b> Are you one of the following? <input type="checkbox"/> Enrolled in Medicaid <input type="checkbox"/> Have no health insurance <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Underinsured (health insurance does not pay for immunizations)		OK to leave message at work on personal voice mail? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Preferred Pharmacy Name and Location:					
If you wish to give Primary Health Medical Group permission to discuss your medical information with someone other than yourself, ask one of our staff members for a <b>Release of Information Authorization Form</b> .						

I have read and agree to Primary Health Medical Group's (PHMG) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby authorize PHMG to furnish insured's insurance company all information (including HIV, sexually transmitted diseases, drug/alcohol abuse, mental illness, or psychiatric treatment) which may be requested concerning my illness or injury. I also authorize the release of information regarding work related injuries to my employer. I hereby assign to PHMG all money to which I am entitled for medical expenses related to the services performed from time to time by PHMG, but not to exceed my indebtedness to PHMG. Any money received from such insurance company over and above such indebtedness will be refunded to me when my bill is paid in full. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside billing service. If my account is sent to an outside billing service there will be a setup fee up to \$20.00 and finance charge(s) (1% per month/APR 12%). Note: Medicare patients will *not* be charged the set up fee or finance charge(s).

MEDICARE BENEFICIARIES: As a Medicare patient, I understand that interest will not be imposed on any outstanding balance. I request that payment of authorized Medicare benefits be made to PHMG. I authorize any holder of medical information about me to release to HCFA and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Responsible Party	<b>X</b>	Date
<b>I have reviewed a copy of Primary Health Medical Group's Privacy Notice.</b>		
Signature	<b>X</b>	Date