PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

Formedic

PAGE # CHART #

NAME	MARITAL STATUS S M W D SEP	DATE OF BIRTH	DATE
STREET ADDRESS		CITY STATE, ZIP	
PHONE # - HOME ( )	WORK # ( )	OCCUPATION/ EMPLOYER	
SPOUSE'S NAME	DATE OF BIRTH	OCCUPATION/ EMPLOYER	PHONE # ( )
IF UNDER 18 **PARENT / GUARDIAN**			
EMERGENCY CONTACT (OTHER THAN SPOUSE)	PHONE # ( )	ADDRESS	RELATION
S.S. #	DRIVER'S LICENSE #	REFERRED BY	

INSURANCE & BILLING INFORMATION

BILLING NAME (IF OTHER THAN PATIENT)			RELATIONSHIP
BILLING ADDRESS			PHONE # ( )

PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) INSURANCE COMPANY	ADDRESS		EFFECTIVE DATE
NAME OF INSURED	RELATION TO PATIENT	GROUP#	BENEFIT CODE
			I.D.#
2) INSURANCE COMPANY	ADDRESS		EFFECTIVE DATE
NAME OF INSURED	RELATION TO PATIENT	GROUP#	BENEFIT CODE
			I.D.#
MEDICARE I.D.#		MEDICAID I.D.#	
OTHER COVERAGE			

TEAR HERE

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. _____ for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICARE — MEDICAID

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be as valid as the original.

PATIENT NAME *(please print)* ..... DATE .....

PARENT / GUARDIAN *(please print)* ..... SIGNATURE .....

HIPAA COMPLIANT