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PATIENT REGISTRATION UPDATE

Patient Name _____ **Date** _____
Last First Middle

Date of Birth _____ **Social Security #** _____

Current Address _____

Name of Employer _____ **Address of Employer** _____

Home Phone (_____) _____ **Work Phone** (_____) _____

Cellular Phone (_____) _____

Current Medical Insurance Information:

Primary Insurance Carrier / Address _____

Secondary Insurance Carrier / Address _____

How is the "Insured" party related Self Spouse Parent Other _____

Does your Insurance company require a formal authorization or referral for exam or treatment from a Primary Care Physician? _____ Yes _____ No

If yes, Physician's name _____

Have you changed Primary Care Physician's _____ Yes _____ No

If yes, Physician's name _____ **Phone Number** _____

Physician's address _____

We will need to make a copy of your current insurance cards.

Financial Responsibility Statement / Release of Information Authorization

I authorize the release of any medical information necessary to my insurance company and the Payment of Benefits to the Physician for services received. I also authorize the release of information to the listed physicians and / or individuals. I understand that this authorization remains valid unless / until I revoke it myself.

X _____ Date _____

Signature of Patient or Legal Guardian

I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist me in this responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my physician and an insurance company, HMO, or other managed entity. If for any reason the account should become delinquent, I am liable to pay for collection and attorney fees.

X _____ Date _____

Signature of Patient or Responsible Party