

PATIENT REGISTRATION FORM

Last Name (Print) (First) (MI) (Previous/Maiden)

Social Security# DOB Marital Status: Single Married Divorced Sep. Widow

Address City State Zip

Home# Cell# Work# Ext

Please circle all the ways the office may communicate with you: Home phone Cell Work Mail (to above address)

How did you hear about us: Doctor Family/Friend Advertising Insurance Social Media

Occupation Employer

PRIMARY CARE DOCTOR City Phone

PHARMACY LOCATION Pharm Phone:

EMERGENCY CONTACT Relationship

Emergency Contact's Home # Work# Cell#

PRIMARY INSURANCE: Insurance Co. Phone#

Name of Insured Patient Relationship to Insured DOB

Insurance Address Employer

Subscriber ID# Group ID# Co-Pay Amount

SECONDARY INSURANCE: Insurance Co. Phone#

Name of Insured Patient Relationship to Insured DOB

Insurance Address Employer

Subscriber ID# Group ID# Co-Pay Amount

Assignment and Release:

- I agree to assign my insurance benefits to be paid directly to the physician.
I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
I authorize the provider or designated representative to contact me by telephone about appointments, billing, and medical care. I may withdraw my permission at any time with written notice.
I authorize the physician to release any medical information required to process a claim.
I acknowledge that I have viewed and been offered a copy of the "Notice of Privacy Practices".
I authorize the disclosure of my protected health information to
I am aware that AAMC is the lab of record, it is my responsibility to inform the staff if my labs need to go to a different diagnostic laboratory.
A fee for no shows may apply

Patient's Signature: Todays date: