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_____

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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_____

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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: _____