Patient Registration Record

Patient Information

Date: _____

_____ _____
Last Name, First Name, MI Maiden Name

_____ _____ _____ _____
Street Address City State Zip

(____) _____-_____ (____) _____-_____ (____) _____-_____ DOB ____-____-___
Home Phone Work Phone Cell Phone MM DD YYYY

Sex: ❒ M ❒ F **SSN:** _____-_____-_____ **Marital Status:** ❒ Married ❒ Single ❒ Other

E-Mail Address _____

Employment Status: ❒ Employed ❒ Full time student ❒ Part time student ❒ Retired

How did you hear about us? Please indicate all that apply. ❒ Friend ❒ Internet ❒ Phone Book ❒ Doctor ❒ Other _____

Primary Insurance Coverage

_____ _____ _____
Insurance Company Name Insurance ID# Group #

Policy Holder Information:

_____
Last Name, First Name, MI

_____ _____ _____ _____
Street Address City State Zip

(____) _____-_____ (____) _____-_____ DOB: ____-____-_____ **Sex:** ❒ M ❒ F
Home Phone Work Phone MM DD YYYY

❒ Self Employed ❒ Not Employed ❒ Retired _____ _____
[---------- **Employment Status** ----------] Name of Employer if Employed Relationship to Patient

Secondary Insurance Coverage

_____ _____ _____
Insurance Company Name Insurance ID# Group #

Policy Holder Information

_____
Last Name, First Name, MI

_____ _____ _____ _____
Street Address City State Zip

(____) _____-_____ (____) _____-_____ DOB: ____-____-_____ **Sex:** ❒ M ❒ F
Home Phone Work Phone MM DD YYYY

❒ Self Employed ❒ Not Employed ❒ Retired _____ _____
[---------- **Employment Status** ----------] Name of Employer if Employed Relationship to Patient

Emergency Contact Information

_____ _____ (____) _____-_____ (____) _____-_____
Last Name, First Name Relation Home Phone Work Phone

_____ _____ (____) _____-_____ (____) _____-_____
Last Name, First Name Relation Home Phone Work Phone

Patient Responsibilities and Acknowledgements:

1. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on the front of this form and have completed all of the answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.
2. I authorize direct assignment of my insurance policy benefits to the doctor for payment of the total charges for professional services rendered. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my account.
3. I understand and agree that payment for services rendered is expected at time of service - this includes all HMO/PPO Co-payments required by the member's contract. HMO/PPO patients will be billed for "Patient Share" balances after insurance pays. The account balance is required to be paid upon receipt of statement..
4. I understand that there will be a **$30** charge for returned checks and I will be expected to promptly reimburse the practice for the amount of the check and the service charge.

Patient/Responsible Party: _____ Date: _____

I acknowledge that I have received a brochure providing the following information and have been given the opportunity to read and ask questions to assure that I understand their contents. I understand that by signing this form, I consent to the provisions of my patient rights, patient responsibilities and the sharing of information as indicated by the **Notice of Privacy Practices**.

1. Notice of HIPAA Privacy Practices 2. Patient Responsibilities 3. Patient Rights Regarding Health Information

_____ _____
Printed Name of Patient/guardian Date

_____ _____
Signature of Patient/guardian Date

Documentation of Good Faith Efforts

I. Patient Name _____ Date _____

The patient presented for treatment on this date and the patient/guardian was provided with a copy of the provider's Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of receipt of the Notice. However, an acknowledgement was not obtained because:

- ❑ Patient refused to sign. Patient was unable to sign or initial because: _____
- ❑ There was a medical emergency (the provider will attempt to obtain acknowledgement at the next available opportunity).
- ❑ Other reason:: _____

Signature of person completing form: _____
