

PATIENT REGISTRATION FORM

Chart No: _____

It is the patient's responsibility to provide accurate information.

Date Registered: _____

Social Security: _____

Name: _____

Birthdate: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer Name: _____ Business Phone: _____

Home Phone: _____ Cell Phone: _____

Emergency Notification (Name and No.): _____

PLEASE READ- IMPORTANT INSURANCE INFORMATION:

- If the insurance is through your husband or a parent, *they are the "Policy Holder"*
- Policy Holder information is required for us to file your claim
- MEDCOST covered patients need to write the name of the employer the plan is provided by, next to the insurance company

Referred by: MD _____, Family/Friend _____, Advertisement _____

PRIMARY Insurance Company: _____

Policy Holder: _____

Policy Holder DOB: _____ SS #: _____

Policy and Group Numbers: _____

SECONDARY Insurance Company: _____

Policy Holder: _____

Policy Holder DOB: _____ SS #: _____

Policy and Group Numbers: _____

ADDITIONAL Insurance Company: _____

Policy Holder: _____

Policy Holder DOB: _____ SS #: _____

Policy and Group Numbers: _____

I understand that I am responsible for my bill regardless of insurance coverage. (With the exception of HMO's, insurance contracts are between the patient and her insurance company, with the insurance company responsible to the patient while the patient remains responsible to the physician.)

If my account should become delinquent, I agree to pay all costs incurred in collecting the account, including a reasonable attorney's fee.

I hereby authorize release of medical information to the above insurance company /companies and authorize payment directly to Kamm, McKenzie, Harden, Smith, Bass, Saacks & White M.D., P.L.L.C.

Signed _____ Date _____

Payment for Services Rendered is Due at the Time of Service