

# OFFICE REGISTRATION FORM

PATIENT INFORMATION FORM TODAY'S

DATE \_\_\_\_\_ REFERRED

BY \_\_\_\_\_ IN ORDER TO SERVE

YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION. ALL INFORMATION IS STRICTLY CONFIDENTIAL. PATIENTS

NAME \_\_\_\_\_

DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ HOME

PHONE \_\_\_\_\_ WORK

PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ ADDRESS

\_\_\_\_\_  
CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_ EMAIL

ADDRESS \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

SPOUSE \_\_\_\_\_ DOB

\_\_\_\_\_  
EMERGENCY CONTACT: NAME

\_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_

PHONE \_\_\_\_\_ PRIMARY INSURANCE

COMPANY \_\_\_\_\_ INSURANCE

CARRIER \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ MEMBER

ID \_\_\_\_\_ GROUP ID

\_\_\_\_\_  
SECONDARY INSURANCE (IF ANY)

COMPANY \_\_\_\_\_ INSURANCE

CARRIER \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ MEMBER

ID \_\_\_\_\_ GROUP ID

\_\_\_\_\_  
PREFERRED

PHARMACY \_\_\_\_\_ ADDRESS

\_\_\_\_\_  
CITY

\_\_\_\_\_  
STATE \_\_\_\_\_

ZIP \_\_\_\_\_

THIS INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE PERFORMANCE OF APPROPRIATE MEDICAL AND/OR SURGICAL PROCEDURES. I AUTHORIZE PAYMENT OF MEDICAL CLAIMS TO THE PHYSICIAN SUPPLIER OF MEDICAL SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL THE CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.

PATIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_ RELEASE OF INFORMATION I authorize the release of information to any specialist to which I am referred by MyPhysician Associates to include office visit notes, labs, diagnostic tests or any other correspondence that will assist the specialist in treating me.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_ I authorize MyPhysician Associates to release any information acquired in the course of my treatment which is necessary to process insurance claims.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_