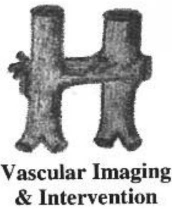

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PATIENT REGISTRATION FORM

Name (Last, first, middle initial) ____________ Date of Birth ____________

Street address ____________ City ____________ State ______ ZIP Code ____________

Please list contact phone numbers in the order you would like to be contacted & circle type:

____________ Home/Work/Cell ____________ Home/Work/Cell ____________ Home/Work/Cell

Language ____________ Ethnicity ____________ **Single __Married _ Divorced_ Widowed** Marital Status (circle one)

Patient Portal:
We currently use an electronic medical record that offers online secure messaging. If you provide an email address we can electronically send you information to register for the Patient Portal. Once logged on you are able to request records, test results, prescription refills, update your information and make appointments. If you are interested in signing up, please provide us with your email address below and you will receive registration directions within 4 business days.

Email ____________ (If not your own, please list relation) ____________

This information will become part of your medical record and will be kept confidential, like all information in your record.

Next of Kin/Contact Person

Name ____________ Relationship ____________ Contact phone number ____________

Physician Information

Primary Care Physician ____________ Cardiologist ____________ Nephrologist ____________ Podiatrist ____________

Insurance Information

Primary Insurance ____________ Policy Number ____________ Subscriber Name ____________ Date of Birth of Subscriber ____________

Secondary Insurance ____________ Policy Number ____________ Subscriber Name ____________ Date of Birth of Subscriber ____________

Signature: ____________ **Date:** ____________

Extended Authorization and Consent

I request that payment under the medical insurance program be made directly to the above names provider on any unpaid bills for services provided on or after the date indicated below. I authorize any holder of medical or other information about me to release to the Social Security administration, its intermediaries or carriers of insurance companies, any information needed for this or a related Medicare or insurance claim. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to obtain the necessary referral and/or authorizations from my primary care and/or referring physician when required. I permit a copy of this authorization to be used in place of the original.