**Patient Registration Form**

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| **Patient Information** | Patient Information |
| Last Name: | First Name: M.I.: | Previous Name (if applicable) |
| Mailing Address: Apt # |
| City/State/Zip: |
| Home Phone: | Cell Phone: | Work Phone: |
| Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages:(Please Select Only One Option)  Voice  Text | If Voice, Please Select Preferred Number: Home  Cell  Work |
| Family Physician or Pediatrician: | Date of Birth: | Sex: Male  Female |
| Marital Status: | Social Security #: |
| Employer Name: | Emergency Contact Name: |
| Emergency Contact Phone #: | Relationship to Patient: |
| **Additional Information and Responsible Party** | Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor |
| Last Name: | First Name: |
| Date of Birth: | Social Security #: | Phone: |
| Address of Person Responsible: |
| City/State/Zip: | Relationship to Patient: |
| Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)** |
| **E-mail Address:** | **Can we leave a message regarding your medical care & test results?**o Yes o No |
| **Race (please select):**o White o American Indian or Alaska Native o Asiano Hispanic o Black or African American o Native Hawaiian or Pacific Islandero Other o Decline | **Ethnicity (please select one):**o Hispanic or Latinoo Not Hispanic or Latinoo Decline |
| **Preferred Language (please select one):** o English o Bosnian o Indian (including Hindi & Tamil)o Sign Language o Spanish o Russian o Other |
| **Preferred Pharmacy Name & Location:** |
| **Insurance Information** | **Primary Medical Insurance Secondary Medical Insurance** |
| Insurance Company Name: | Insurance Company Name: |
| Policy Holder Name: | Policy Holder Name: |
| Policy Holder's Date of Birth: | Policy Holder's Date of Birth: |
| Policy Holder's Social Security #: | Policy Holder's Social Security #: |
| Patient Relationship to Policy Holder: | Patient Relationship to Policy Holder: |
| I certify that I have read and agree to Primary Health Medical Group's (PHMG) payment policy. I am eligible for the insurance indicated on this form, and I understand that payment is myresponsibility regardless of insurance coverage. I hereby assign to PHMG all money to which I am entitled for medical expenses related to the services performed from time to time by PHMG, but not to exceed my indebtedness to PHMG. I authorize PHMG to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from PHMG by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to PHMG. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. |

**I have reviewed a copy of Office’s Privacy Notice.** c **(Initials)**

 **Signature of Responsible Party: X Date:**

 **Printed Name of Responsible Party: X Date:**