**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 Asian  o Hispanic o Black or African American o Native Hawaiian or Pacific Islander  o Other o Decline | | | | **Ethnicity (please select one):**  o Hispanic or Latino  o Not Hispanic or Latino  o 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 my  responsibility 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:**