

## PATIENT REGISTRATION

Today's date: \_\_\_\_\_ Dr. \_\_\_\_\_

Patient's full name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex:  Male  Female Home phone: \_\_\_\_\_

Patient employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Work phone: \_\_\_\_\_

Employment status:  Full Time  Part Time  Not Employed  Self Employed  Retired  Student

Marital status:  Single  Married  Divorced  Separated  Widowed

Responsible for payment: \_\_\_\_\_

If married, your spouse's full name \_\_\_\_\_  
Last First Middle

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Work phone: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

\*Do you have any know allergies? \_\_\_\_\_

**OTHER MEMBERS IN HOUSEHOLD:**

1. \_\_\_\_\_ DOB: / / 4. \_\_\_\_\_ DOB: / /

2. \_\_\_\_\_ DOB: / / 5. \_\_\_\_\_ DOB: / /

3. \_\_\_\_\_ DOB: / / 6. \_\_\_\_\_ DOB: / /

## INSURANCE INFORMATION

Referral required:  Yes  No

Insurance name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Coverage date \_\_\_\_\_

Insurance company phone #: \_\_\_\_\_

Precertification phone # (if applicable): \_\_\_\_\_

Subscriber (Name policy is under): \_\_\_\_\_

Contract, ID or subscriber number: \_\_\_\_\_

Group number: \_\_\_\_\_

Medicare number: \_\_\_\_\_

Medical assistance number: \_\_\_\_\_

Patient Acct. # \_\_\_\_\_ Bill code \_\_\_\_\_

Records Release: I hereby authorize the release of any information by Duluth Family Practice Center, to my referring doctor and/or insurance company or its representatives on behalf of myself and/or dependents

\_\_\_\_\_  
Date Signature

Assignment of Benefits: I hereby authorize payment of medical benefits to Duluth Family Practice Center for services rendered to myself and/or dependents.

I understand that I am responsible for payment on my account regardless of insurance. If my insurance fails to pay on my claim 60 days after service, I will make payment on my account and I will contact my insurance company for payment.

\_\_\_\_\_  
Date Signature

**MEDICARE PATIENT SIGNATURE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made on my behalf to Duluth Family Practice Center for any services furnished me by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Chart # \_\_\_\_\_