Meetinghouse Family Physicians

Patient Registration Form (1)

Patient information:

Date: _____

Last Name:

First Name: MI.

Mailing Address: _____

City: _____ State: _____ Zip: _____

Doctor: _____

Date of Birth: _____ Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Widowed ❑ Separated ❑ Married ❑ Divorced ❑ Partner

Telephone Home: _____ Cell: _____

Work: _____ Ext: _____

Social Security#:

Employer:

Name:

Tel:

Employment Status:

❑ Full-time ❑ Part-time ❑ N/A ❑ Full-time ❑ Not employed

❑ Self-employed ❑ Retired ❑ Active Military ❑ Part-time

Billing Information:

Responsible Party ❑ Self ❑ Other

(If other):

Name: _____

Address: _____

Tel: _____

Relationship to patient: _____

Is this person a current patient in this office? ❑ Yes ❑ No

Emergency Contacts:

1) Name: _____ Tel: _____

2) Name: _____ Tel: _____

Other family members who will be patients in this office (name and relationship)

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Patient Registration Form (2)

Insurance Information: (Please provide current insurance information)

I. Primary Insurance: _____

- Name of Insured: _____
- Insured's Date ofBirth: _____
- Insured's SSN: _____

2. Secondary Insurance:

Patient Information:

1. Name: _____ **DOB:** _____

2. Street Address: (if different from mailing address):

_____

_____

3. Telephone: (H) _____ (W) _____

(C) _____ Email: _____

- May we leave a message at home? ❑ Yes ❑ No At work? ❑ Yes ❑ No

Employer: (name and address) _____

_____

Pharmacy: (name/location) _____

Tel: _____

Release of Medical Information:

❑ NO I **do not** allow my provider to release billing data to my insurance carrier. I understand that my claims will be filed to insurance by my provider.

❑ YES I do permit provider to release medical billing data to my insurance carrier.

I request payment of authorized benefits be made to **Meetinghouse Family Physicians** or any services provided to me by the physician. I authorize any holder of my medical information to release to the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related services. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature: _____ Date: _____