

Patient Registration Form

Patient Demographics

Name: _____		SS#: _____	
Address: _____		City, State, Zip: _____	
Home #: _____	Work #: _____	Cell #: _____	
Birthdate: _____	Gender: _____	Marital Status: _____	
E-mail Address: _____			
Primary Physician: _____		Referring Physician: _____	
Employer: _____		Employer Phone #: _____	
Employer Address: _____			
Spouse / Guardian Name: _____			
Spouse / Guardian Phone #: _____		Spouse / Guardian SS#: _____	
Is today's visit for a work-related injury or other type of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Visitor / Tourist Information: (hotel name, phone, room #, etc) _____			
Where did you learn about this physician / clinic? <input type="checkbox"/> Radio (RA) <input type="checkbox"/> Newspaper (NP) <input type="checkbox"/> Television (TV) <input type="checkbox"/> Direct Mail (DM)			
_____ Emergency Room (ER) <input type="checkbox"/> Brochure (BR) <input type="checkbox"/> Billboard (BB) <input type="checkbox"/> Urgent Care (UC) <input type="checkbox"/> Physician (PH) <input type="checkbox"/> Skaggs Nurse Advice Line (AL)			
_____ Friend / Family Member (FF) <input type="checkbox"/> Phone Book Yellow Pages (YP) <input type="checkbox"/> Other (O): _____			

Emergency Contact

(Please list someone outside of your household.)

Name: _____	Relationship: _____	Phone #: _____
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Insurance Information

(Please provide your insurance cards and a picture ID to the receptionist)

Primary Insurance: _____	Secondary Insurance: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber DOB: _____	Subscriber DOB: _____
Subscriber SSN: _____	Subscriber SSN: _____
Relationship of Insured to Patient: _____	Relationship of Insured to Patient: _____

Responsible Party Information

(Fill out if patient is a minor or if there is another person / 3rd party that is responsible)

Name / Company: _____		
Address: _____		
Phone # _____	SS#/Policy#: _____	DOB: _____

AUTHORIZATION FOR TREATMENT:

The undersigned patient and/or responsible relative or legal guardian hereby consents to allow physicians, other healthcare providers, and medical/nursing personnel of Skaggs Community Health Center and its clinics to administer and perform all medical examinations, diagnosis, treatments, and procedures which are deemed necessary and for which the patient or legal guardian voices no specific objections. I understand that medicine is not an exact science and that no guarantee or assurance has been made as to the results which may be obtained.

AUTHORIZATION FOR FINANCIAL AGREEMENT AND PAYMENT:

All charges not covered by insurance are due in full at the time of service. The undersigned assumes financial responsibility for examinations, treatments, procedures, and all other services provided. Any other arrangements must be made prior to care and noted by the receptionist. I authorize direct payment of all medical benefits to Skaggs Community Health Center and its clinics and agree upon demand to pay said facility whatever sum of money that may become due on this account.

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize release of information to the financially responsible party, insurance company, or federal/state payer as is appropriate for billing and receiving payment for any and all medical services provided by Skaggs Community Health Center and its clinics.

AUTHORIZATION FOR MEDICARE AND MEDICAID BILLING:

I certify that all information given is true and correct to the best of my knowledge and to be used for payment under Title XVIII and Title IX of the Medicare and Medicaid Billing Requirements Act and that no other payment source should be billed prior to submission of this claim to a federal payer. The showing of a Medicare or Medicaid card shall serve as representation the above listed patient is indeed an eligible beneficiary of the program being billed for above said medical services. I agree to be responsible for any and all charges should this not be the case.

Signature of Patient / Legal Guardian

Date