Patient Registration

PLEASE PRINT

Last Name:______________________________________
First Name:______________________________________
Middle Name:_____________________________________
Sex:________ Date of Birth:______________________
Social Security No.:______________________________
Address: ____
Zip: ____
City:___________________ State:___________________
Home Phone: ( )_________________________________
Work Phone: ( )_________________________________

Marital Status: __________________________________
Mobile Phone: ( )________________________________
Email address on file (please add if blank):

____

Race: ____
Ethnicity: _______________________________________
Language:_______________________________________

Emergency Contact Information

Name:____
Phone:( )_______________________________________
Contact Relationship: ____________________________
Name:____
Phone: ( )______________________________________

Guarantor Information (to whom statements are sent).

Last Name:______________________________________
First Name:______________________________________
Middle Name:____________________________________

Preferred Pharmacy:

____

Primary Insurance Information

Insurance Plan Name:______________________________

Address to Send Claims:____________________________

Policy Information

Patient’s relationship to policy holder:_______________
ID/Certification No.: _____________________________
Policy/Group No.: ________________________________
Issue Date: _____________________________________
Exp Date: ______________________________________
Copay Amount ___________________________________
Co-insurance Percent _____________________________

Policy Holder

Last Name: ______________________________________
First Name:______________________________________
Middle Name:_____________________________________
Address: ____
City: _______________State:__________Zip:_____________
Social Sec Number:______-_______-______________
Date of Birth: ___/______/______________Sex: M or F
Employer:____

Secondary Insurance Information

Insurance Plan Name:______________________________

Address to Send Claims:____________________________

Policy Information

Patient's relationship to policy holder: _______________
ID/Certification No.: _____________________________
Policy/Group No.: ________________________________
Issue Date:______________________________________
Exp Date:_______________________________________
Co pay Amount:___________________________________
Co-insurance Percent:______________________________

Policy Holder

Last Name: ______________________________________
First Name: ______________________________________
Middle Name:_____________________________________
Address:____
City:_____________________ State:__________ Zip:_________
Social Sec Number:______-_______-______________
Date of Birth:____/______/_______ Sex: M or F
Employer:____

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process this claim to my employer, prospective employer and/or insurance carrier.

Signed: ____ Date: ________________________________

MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE: I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Providence Physician Partners – Mesa Hills. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signed: ____ Date: ________________________________

FINANCIAL OBLIGATION: I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am fully responsible for any and all charges not covered by my insurance carrier. I understand that payment may be requested at the time of service or I may be billed for such services subsequently.

Signed: ____ Date: ________________________________

CONSENT FOR TREATMENT: I hereby authorize the physician, nurses, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

Signed: ____ Date: ________________________________

ADVANCED DIRECTIVE: Do you have an advance directive (living will/power of attorney)? ______Yes______No If yes, please provide a copy for our records.