Dedicated Medical Care

Patient Registration

Last Name _____ First Name _____ MI_____ Male Female

Address _____ City/State_____ Zip_____

Home Phone _____ Work# _____

Cell#_____

Personal E-Mail Address: _____

Date of Birth _____ Social Sec # _____

Marital Status Single Married Divorced Widowed Other Employer _____

Emergency Contact _____ Relationship_____ Phone #_____

Primary Care Physician _____ Phone#_____ Fax#_____

Name of Referring Physician or Other Referral Source: _____

_____

Primary Insurance _____ ID #_____

_____ _____ _____

Print name of policy holder | Policy holder date of birth | Relationship to patient

Secondary Insurance _____ID #_____

_____ _____ _____

Print name of policy holder | Policy holder date of birth | Relationship to patient

_____

If you authorize anyone in your family, a friend, or a personal caregiver **to receive this information** please **complete this form** and return to the receptionist.

Please indicate if you authorize the office to leave messages on you home answering machine **Yes** **No**

____Test results ____Billing information _____Medication information

List any person who is able to receive you protected health information and what information we are able to share with them.

1. _____

_____Test results _____Billing information _____Medication information

2. _____

_____Test results _____Billing information _____Medication information

_____ _____

Signature **Date**