PATIENT REGISTRATION / Consent to Treat

Please print the information below and have your insurance card and legal photo ID available for the receptionist to scan.

PATIENT INFORMATION

Social Security # ___-____-_______ Last Name __________________ First Name _______________ Middle ____

Address ____ City ________________ St _____ Zip __________

Home Phone (____)____-______ Work Phone (___)____-_______ Ext. _______ Email: ________________________

Date of Birth ___________ Marital Status __________ Race ______ Sex ___ Alternate Phone (____)____-________

Emergency Contact ____ Phone (_____)_______-______
(Name) (Relationship)

Patient Employer ____________________ Emp. Address _________________________ Emp. Phone (___)_____-_____

Pharmacy most used by patient _______________________________________ Pharm. Phone (_____) ____-_______

Referring Provider (Specialist office only) ____

PERSON WHO SHOULD RECEIVE THE BILL - RESPONSIBLE PARTY (Guarantor)

Relationship to Patient: Self Parent Spouse Other _____________________________

Social Security # ____-____-_____ Name ____

Address ____ City _______________ St _____ Zip ___________

Home Phone (____)____-_______ Work Phone (___)____-_______ Ext. ________ Email: _________________________

Date of Birth ___________ Marital Status __________ Race ______ Sex ___ Alternate Phone (____)_____-________

Employer __________________________ Emp. Address _________________________ Emp. Phone (____)____-_____

PRIMARY INSURANCE COMPANY NAME____ **No Insurance**
(Circle if applicable)

Subscriber Relationship to Patient: Self Parent Spouse Other __________________________

Subscriber Name: ____________________________________ Date of birth ______________ SS# ____-___-________

Employer ______________________________________ PCP ___________________________ Copay _______________

SECONDARY INSURANCE COMPANY NAME____

Subscriber Relationship to Patient: Self Parent Spouse Other _____________________________

Subscriber Name: ____________________________________ Date of birth ______________ SS# ____-___-________

Employer ____ Copay ______________

I understand that I am responsible for payment for all services rendered. I authorize St. Elizabeth Physicians to act as my agent in helping me obtain payment from my insurance companies. I authorize payment be made directly to St. Elizabeth Physicians. I authorize release of information to all my insurance companies which may be necessary to collect any payments. I further authorize release of medical information to any and all providers involved in my care. I permit a copy of this authorization to be used in the place of the original. I authorize the use of “signature on file” to be used on all of my insurance submissions. I understand that I am responsible for notifying the office of any precertification or referral needed for my insurance. According to recognized coding rules, you may receive separate charges for procedures, physicals and/or other problems during a single visit.

I further authorize the access of my clinical and medication information for treatment by my Primary or Specialty Care Provider and to any and all providers directly involved in my care.

Signature X ____ Date ____________________
(Signature of patient or patient representative)

Witness ____