INTERNAL MEDICINE PHYSICIANS P.C.

PATIENT REGISTRATION **TODAY'S DATE** _____

FIRST NAME _____ MIDDLE INITIAL_____ LAST NAME_____

PREFERRED NAME (if different than legal name) _____ DATE OF BIRTH _____ GENDER_____

SOCIAL SECURITY # _____ MARITAL STATUS Single Married Divorced Widowed Other_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____WORK_____ CELL PHONE _____

PATIENT EMAIL_____

EMPLOYER _____ OCCUPATION _____

EMERGENCY CONTACT_____ PHONE _____ HOW RELATED?_____

IF MARRIED, SPOUSES'S NAME _____ SOCIAL SECURITY # _____

SPOUSE'S EMPLOYER _____ DATE OF BIRTH _____

GUARANTOR (PERSON RESPONSIBLE FOR BILL.) IF SAME AS PATIENT, CHECK SAME HERE ☐

NAME _____ RELATION TO PATIENT _____

ADDRESS _____ DATE OF BIRTH _____

CITY _____ STATE _____ ZIP _____ SOCIAL SECURITY # _____

EMPLOYER _____ PHONE _____ HOME PHONE # _____

INSURANCE COVERAGE INFORMATION
PLEASE BE PREPARED TO PRESENT YOUR INSURANCE CARD(S) AT EVERY VISIT

Primary Insurance

_____

ADDRESS _____

POLICY # _____GROUP #_____

SUBSCRIBER _____

DATE OF BIRTH _____

RELATION TO PATIENT _____

Secondary Insurance

_____

ADDRESS _____

POLICY # _____ GROUP # _____

SUBSCRIBER _____

DATE OF BIRTH _____

RELATION TO PATIENT _____

INSURANCE AND ASSIGNMENT OF BENEFITS AUTHORIZATION INFORMATION

I hereby authorize treatment of the above-named patient and agree to pay all charges for treatment regardless of insurance coverage or the pendency of insurance claims.

I authorize the release of all medical information to the above insurance carriers that is pertinent to my medical care and necessary to process my insurance claims. I will assign all medical and surgical benefits to Internal Medicine Physicians, P.C. A photocopy of this form shall be as valid as the original. I understand that I can withdraw this medical benefit assignment at any time by notifying this office in writing.

I HAVE READ THIS INFORMATION THOROUGHLY AND UNDERSTAND IT.

PATIENT SIGNATURE _____DATE _____

(PARENT OR LEGAL GUARDIAN IF MINOR)