

PATIENT REGISTRATION FORM

****Today's Date:** _____ **Clinic Name:** _____

PATIENT INFORMATION: (Please use full legal name, no nicknames)

*Last Name: _____ *First Name: _____ Middle Initial: _____

*Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ - _____ *Social Security #: _____

*Date of Birth: _____ Age: _____ *Sex: _____ Marital Status: _____ Drivers Lic#: _____

*Employer Name and Address: _____

Work Phone #: (_____) _____ - _____

E-mail Address: _____ Cell Phone #: (_____) _____ - _____

Emergency Contact Name: _____ Emerg Phone #: (_____) _____ - _____

Please tell us how you heard about us: _____ *Referred by* _____

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

*Relationship of Guarantor to Patient: Self _____ Spouse _____ Parent _____ Other _____

*Last Name: _____ *First Name: _____ Middle Initial: _____

*Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ - _____ *Social Security #: _____

*Date of Birth: _____ Age: _____ *Sex: Female _____ Male _____

*Employer Name and Address: _____

Work Phone #: (_____) _____ - _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name : _____ *Insured's Name: _____

Insured's Social Security #: _____ *Insured's Date of Birth: _____

*Policy / ID #: _____ *Group #: _____ Eff Date: _____

Claims Address & Phone: _____

SECONDARY INSURANCE:

Plan Name : _____ *Insured's Name: _____

*Insured's Social Security #: _____ *Insured's Date of Birth: _____

*Policy / ID #: _____ *Group #: _____ * Eff Date: _____

Claims Address & Phone: _____

***REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS.**

Please read and sign back of form.

**PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS**

Patient Name: _____ **Date of Birth:** _____
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to **RUPINDER K MANN** or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that MedicalEdge is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to **RUPINDER K MANN** or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the **RUPINDER K MANN M.D.** Information Privacy Policy. I hereby authorize **RUPINDER K MANN** or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize **RUPINDER K MANN M.D.** representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying **RUPINDER K MANN** to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my MedicalEdge physician or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If different from patient)

GUARANTOR NAME (Please Print): _____