PROVIDENCE MEDICAL GROUP

PATIENT REGISTRATION SHEET

Location _____ Doctor _____

Referring Physician _____ Family Physician _____

Patient's Name _____ (last / first / middle initial) Male ___ Female ___ Birthdate _____

Street _____ City _____ State _____ Zip _____ Age _____

Home Phone (____) _____ Cell/Pager (____) _____ E-mail _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ SS# _____

Employer _____ (last / address) Work# (____) _____

Spouse's Name _____ Birthdate _____ SS# _____

Spouse's Employer _____ (name / address) (____) _____ (phone#)

RESPONSIBLE PARTY 18 years or older (if different from patient) Relationship _____

Name _____ SS# _____

Street _____ City ____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____

Employer _____ (name / address) (____) _____ (phone#)

Primary Insurance Company _____

Claim Mailing Address _____ City _____ State ____ Zip _____

Phone (____) _____ ID# _____ Group# _____

Insured's Name _____ Relationship _____

Effective Date _____ through _____ SS# _____ Birthdate _____

Secondary Insurance Company _____

Claim Mailing Address _____ City _____ State ____ Zip _____

Phone (____) _____ ID# _____ Group# _____

Insured's Name _____ Relationship _____

Effective Date _____ through _____ SS# _____ Birthdate _____

Next of Kin (other than spouse) _____

Relationship _____ Phone (____) _____

AUTHORIZATION FOR TREATMENT / ASSIGNMENT OF BENEFITS: I hereby authorize treatment and authorize any holder of medical or other information about me to release to the Health Care Financing Administration, its agents, or my private carrier any information needed to determine these benefits or any benefits for related services. I request that payment of authorized Medicare, MediGap and / or private benefits be made either to me or on my behalf to Providence Medical Group for any services furnished by that supplier, including my physician services.

I hereby agree to pay Providence Medical Group the charges for all medical services rendered. I shall also be responsible for any attorney fees required to collect for these services, court costs, and collection agency fees, to which may be added pre-judgment and/or post-judgment interest at the current legal rate.

Signature _____ Date _____ Employee's Initials _____

(patient/parent if minor dependent)