

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Please complete this form to assist your physician in accurately maintaining your personal professional record. Please fill in all information that applies.

Title Name	First	M.I.	Last
Address		City	State Zip
Home Phone	Work Phone	Alternate Phone # (Cell)	SS #
Birthdate	Age	Sex (circle one) M F	Race Marital Status Spouse's Name
Patient Employer		Patient's Occupation	
Address		City	State Zip

RESPONSIBLE PARTY (If other than patient)

Name/First	M.I.	Last
Address		City State Zip
Home Phone	Work Phone	SS #
Employer	Address	City State Zip

INSURANCE INFORMATION

Primary Insurance Company		Relationship to Patient	Phone
Address		City	State Zip
Insured's Name	ID #	Group #	Birthdate of Insured
Secondary Insurance Company		Relationship to Patient	Phone
Address		City	State Zip
Insured's Name	ID #	Group #	Birthdate of Insured

Primary Care Physician		Phone
Address		City State Zip
Nearest Relative (not living with you)	Relationship to Patient Phone #	
Address		City State Zip
Whom may we thank for referring you?		Date

(OVER PLEASE)

ALL PATIENTS:

1. I consent to treatment necessary for the care of the above named patient.
2. I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information to the physicians involved in my medical care and to my insurance company, if applicable.
3. I permit fax transmittal of my protected health information.
4. I understand that payment of all co-pays, deductibles and services not covered by insurance is due at the time of service unless other financial arrangements have been made prior to treatment.
5. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to E. Daniel Biggerstaff, III, M.D. I fully understand that I am responsible for all charges incurred as a result of services rendered to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original.
6. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

SIGNATURE

DATE

MEDICARE PATIENTS:

1. I request that payment of Medicare/Other Insurance company benefits be made either to me or on my behalf to E. Daniel Biggerstaff, III, M.D. for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.
2. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

SIGNATURE

DATE