

Patient Registration Information

Please **PRINT AND** complete ALL sections below!

PATIENT'S INFORMATION

Marital Status ___ Single ___ Married ___ Divorced ___ Widowed **Sex:** ___ Male ___ Female

Name: _____

Last name First Name initial

Date of Birth ___ / ___ / ___ Age ___ EMAIL Address: _____

Home Phone: (___) _____ Work Phone (___) _____ Cell Phone: (___) _____ Social Security # _____

Address: _____ Apt. #: _____ City: _____ State: ___ Zip: _____

Relationship to Patient: ___ Self ___ Spouse ___ Child ___ Other: _____

Name: _____

Last name First Name initial

Date of Birth: ___ / ___ / ___ Social Security #: _____ - _____ - _____

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

Address: _____ Apt. #: _____ City: _____ State: ___ Zip: _____

Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____

Address: _____ City: _____ State: ___ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured:

___ Self ___ Spouse

___ Child ___ Other

Policy #: _____ Group #: _____ Copay: \$ _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ___ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured:

___ Self ___ Spouse

___ Child ___ Other

Policy #: _____ Group #: _____ Copay: \$ _____

PAST MEDICAL RECORDS (Prior Primary Care Doctor)

Name: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone: (___) _____ Fax: (___) _____

PHARMACY INFORMATION

Name: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone: (___) _____ Fax: (___) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Park Avenue Medical, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____