PATIENT REGISTRATION FORM

PATIENT INFORMATION

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

MUST BE COMPLETED OR WE WILL NOT FILE YOUR INSURANCE

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

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

INSURANCE INFORMATION

Primary Insurance Company		Phone	
Address	City	State	Zip
Insured's Name	ID #	Group #	
Secondary Insurance Company			
Address	City	State	Zip
Insured's Name	ID #	Group #	

May we call you at work ____Yes ____No

Can confidential messages be left at your **place of employment** on your voicemail __Yes ___No

Can confidential messages be left at your **home** on your voicemail ____Yes ____No

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____________ and assign directly to JB Internal Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature ______________________________________Date____________