

Mary Black Physician Group

Patient Information: This Section refers to the **PATIENT ONLY**

Account Number: _____	Chart Number: _____
Social Security Number: _____	Employed _____ Retired _____
Last Name: _____ Jr., II, _____	Employer _____
First Name: _____ Middle Name: _____	Address: _____
Maiden Name: _____ Spouse Name: _____	_____
Address: _____	Zip Code: _____
Zip Code: _____ City: _____ State: _____	City/State: _____
E-mail Address: _____@_____.	Marital Status: _____
Home Phone: (____) _____	Primary Care Physician: _____
Work Phone: (____) _____	Primary Care Physician Phone: _____
Birth Date (mm/dd/yy): _____ Sex: Male Female	If Student: Full-Time Part-Time

Responsible Party: This section refers to the **PERSON/PARTY WHO SHOULD RECEIVE THE BILL**

Relationship to Patient: Self (skip to next section) Parent Spouse Employer Other: _____	
Social Security Number: _____	If Employed, Employer: _____
Last Name: _____ Jr., II, _____	_____
First Name: _____ MI _____	Address: _____
Address: _____	_____
Zip Code: _____ City: _____ State: _____	Zip Code: _____
Home Phone: (____) _____	City/State: _____
Work Phone: (____) _____	_____
Birth Date (mm/dd/yy): _____ Sex Male Female	If Student: Full Time Part Time

Subscriber Information: This section refers to the **PERSON IN WHOSE NAME THE INSURANCE IS LISTED**

Relationship to Patient: Self (skip to page 2) Parent Spouse Other: _____	
Social Security Number: _____	If Employed, Employer: _____
Last Name: _____ Jr., II, _____	_____
First Name: _____ MI _____	Address: _____
Address: _____	_____
Zip Code: _____ City: _____ State: _____	Zip Code: _____
Home Phone: (____) _____	City/State: _____
Work Phone: (____) _____ Ext _____	_____
Birth Date (mm/dd/yy): _____ Sex: Male Female	If Student Full Time Part Time

Please ensure the office has a copy of your most recent insurance card(s)

INSURANCE COVERAGE INFORMATION: Please show all numbers on your card(s).

PRIMARY INSURANCE COVERAGE:

Insured (Name on Card) _____ Insured ID Number: _____
Insurance Co. Name: _____ Group/Member/Policy Number: _____
Address: _____ Effective Date: _____

SECONDARY INSURANCE COVERAGE

Insured (Name on Card) _____ Insured ID Number: _____
Insurance Co. Name: _____ Group/Member/Policy Number: _____
Address: _____ Effective Date: _____

IN CASE OF EMERGENCY....

Name, Relationship, and Phone number of Emergency Contact:

GENERAL CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT

The patient referred on the registration forms, either personally or through the person legally empowered to give this consent and obligate the patient as herein contemplated, requests and authorizes this office, its employees, agents, and other affiliates to provide general care for this and all subsequent requests for care. This will include, without limitation, routine diagnostic procedures and medical treatments, which is to include whatever procedures that are deemed necessary by the attending doctors or their affiliates.

Date Signature of Patient and/or Guardian if patient is Minor

MEDICAL RECORDS RELEASE

I authorize release of my medical records to _____ and permit a copy of this authorization to be used as the original.

Date Signature of Patient and/or Guardian if patient is Minor

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN....

I hereby authorize the office of Mary Black Physician Group to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, co-payment, deductible, and non-covered services.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mary Black Physician Group for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Date Signature of Patient and/or Guardian if patient is Minor

How were you referred to the practice...

Dr. _____ Friend/Relative Radio Newspaper Hospital Referral Service Other: _____