

Date _____

NEW ACCOUNT

CHANGE _____

PATIENT REGISTRATION
Please complete all lines, print all information

LAST NAME	FIRST NAME	INT.

STREET ADDRESS

CITY	STATE	ZIP CODE

BIRTHDATE	SEX	SOCIAL SECURITY NUMBER	AREA	TELEPHONE

If patient is a minor: _____ E-mail Address: _____
Mother's Name: _____ Spouse: _____
Father's Name: _____ Patient's Work #: _____

INFORMATION ON THE PERSON WHO CARRIES THE INSURANCE

LAST NAME	FIRST NAME	INT.

STREET ADDRESS

CITY	STATE	ZIP CODE

AREA	TELEPHONE	SOCIAL SECURITY NUMBER	BIRTHDATE

EMPLOYMENT OF PERSON WHO CARRIES THE INSURANCE

Employer: _____ Employer Phone: _____
Employer Address: _____

NEAREST RELATIVE NOT AT YOUR RESIDENCE

Name: _____ Relationship: _____
Address: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Insured: _____

Policy, or SS NO. _____

Secondary Insurance: _____

Insured: _____

Policy, or SS NO. _____

Signed _____ Date _____

Relationship to Patient: _____ Account # _____

Referring Physician: _____

Primary Care Physician: _____

MEDICARE ASSIGNMENTS OF BENEFITS

Medicare patients are responsible for their annual deductible. Medicare does not remit payment to the physician until you deductible has been met. Your secondary insurance will be billed whenever possible; however, you are responsible for your 20% balance or any non-covered services.

I request that payment by the medical insurance program be made directly to this physician on any unpaid bills for services furnished to me by that physician during the period indicated above not to exceed one calendar year.

I authorize release to SSA's carriers any information needed to process this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original.

SIGNED: _____ DATE: _____

CHAMPUS/CHAMPVA ASSIGNMENT

"I request that payment of authorized benefits be made either to me or on my behalf to Dr. _____, for any services furnished me by that physician. I authorize any holder of medical information about me to release to OCHAMPUS and its agents any information needed to determine these benefits or the benefits payable for related services."

SIGNED: _____ DATE: _____