PATIENT REGISTRATION

Patient ID: **Date:**

PLEASE PRINT

Last Name: _____
First Name: _____Middle Initial_____
Gender: Male Female
Date of Birth: _____
Social Security No.:_____
Address:_____
Zip:_____
City:_____ State: _____
Email Address:
_____
Home Phone:_____
Work Phone:_____
Mobile Phone:_____
Patient's Primary Care Physician: _____
Marital Status:_____

How did you hear about us?
advertising word of mouth another patient
hospital another physician insurance company

Guarantor Information
(to whom statements are sent)

Name:_____
Address:_____
Phone:_____
Relationship to Patient:_____

Emergency Contact Information

Name:_____
Relationship to Patient:_____
Phone:_____

Employer Information

Name:_____
Phone:_____

Other:

Patient Referred by:_____
Preferred Pharmacy:_____

Are you a member of the Senior Circle group at KCH?
Yes or No (please circle)

Insurance Information

Primary Insurance - Policy Holder

Last Name:_____
First Name:_____
Middle Name:_____
Address:_____
City, State, Zip:_____
Social Security No.:_____
Date of Birth:_____ Gender: M F
Employer:_____
Patient's relationship to policy holder:_____

Secondary Insurance - Policy Holder

Last Name:_____
First Name:_____
Middle Name:_____
Address:_____
City, State, Zip:_____
Social Security No.:_____
Date of Birth:_____ Gender: M F
Employer:_____
Patient's relationship to policy holder:_____

Your patient information may be used to contact you by telephone/mail for the purpose of treatment, payment or health care operations. If you have any restrictions for communication with you please let us know on the line below.

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I authorize treatment of the person named and authorize information given to the insurance companies. I agree to pay all charges and interest shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing with the practice. It is agreed that payment will not be delayed or withheld because of any insurance coverage of the pendency of claims thereon, and that all proceeds of the insurance for services rendered in the practice are assigned to Kosciusko Medical Group, LLC but without the clinic's assuming sole responsibility for the collection thereof.

Have you received a copy of our privacy notice? ☐ Yes ☐ No

Signature:_____ Date:_____

Relationship if other than patient:_____ *Office use only:* Office Staff Initials _____