Patient Registration Form

Patient Info:
Name:
Address:

Home Phone:
Work Phone:
E-Mail Address:

Employer:

SSN:
Date Of Birth: Race:
Gender: Age:
Marital Status:

Physician Info:
Primary Care Phys:
Referring Phys:
Group Phys:
PenChart ID:
Other PenChart #:
Self Pay Balance:

Lab Info:
Preferred Lab:
Phone: Fax:

Pharmacy Info:
Preferred Pharmacy:
Address:
City, State Zip:
Phone:

Emergency Contact:
Name:
Address:
City, State Zip:
Home Phone:
Work Phone:
Relationship:

Guarantor Info:
Name:
Address:
City, State Zip:
Home Phone: Work Phone:
E-Mail Address:
Date of Birth: SSN:

Family Members Info:

Name	Date of Birth	SSN	Relationship

Insurance Name	Priority	Phone	Subscriber	Employer	Rel To Ins	Cert. #

Referral Info:

Insurance/Account Plan	Certificate Number	Visit Types	Provider	Referring Provider	Referral Count

Signature ______________ Date ______________

STATEMENT OF PAYMENT POLICY

Endocrine Metabolic Medical Center expects payment for service on the date the service is rendered.

STATEMENT OF MEDICARE POLICY

Endocrine Metabolic Medical Center is not certified with Medicare. Patient will be responsible for payment of services on the date rendered.

STATEMENT OF MEDI-CAL POLICY

Endocrine Metabolic Medical Center will not accept new Medi-Cal patients.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize Endocrine metabolic Medical Center to use the signature(s) below as authorization to release medical or other information necessary to process any claims. I also authorize payments of medical benefits to Endocrine Metabolic Medical Center for services provided. I agree to be fully responsible for payment.

NOTICE OF RESPONSIBILITY

In the era of rapidly changing health care coverage, we must remind you that the financial responsibility for your medical care is yours.

Medicare and Health plan rules often require that lab, x-ray and other testing be done in certain designated facilities. It is your responsibility to know these restrictions on your health care and to have testing done as your health plan permits. We will make every effort to provide care under the guidelines of your health care plan. However, we cannot be financially responsible in the event of after-the-fact decisions of health plan administrators that a procedure was done improperly or in the wrong institution.

Your health is of paramount importance to Endocrine Metabolic Medical Center. Thank you for having confidence in us.

I certify that I have read and understand the above statements.

______________________________ ______________________________

Patient's Signature Date