INSURANCE/ PATIENT REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

PATIENT'S LAST NAME FIRST NAME M.I.			SOCIAL SECURITY #	DATE OF BIRTH	AGE
STREET ADDRESS APT #			SPOKEN LANGUAGE	GENDER (circle one) Male Female Transgender	
CITY	STATE	ZIP CODE	BEST PHONE # ( )	MARTIAL STATUS S M W D	
EMPLOYER NAME ADDRESS			PATIENT'S WORK # ( )	OCCUPATION	

RACE ☐American Indian or Alaska Native ☐ Black or African American
☐ Asian ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Refused to report

Ethnicity: ☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Refused to report

PATIENT PREFERRED METHOD OF CONTACT:	E-MAIL ADDRESS:

EMERGENCY CONTACT PERSON RELATIONSHIP TO PATIENT CONTACT #

GUARANTOR/ POLICY HOLDER INFORMATION (Person responsible for payment, if other than other)

GUARANTOR'S NAME (<u>If different from patient</u>)	RELATIONSHIP TO PATIENT	
GUARANTOR'S ADDRESS APT #	SOCIAL SECURTITY #	DATE OF BIRTH
CITY STATE ZIP CODE	HOME PHONE # ( )	GENDER MALE FEMALE
GUARANTOR'S EMPLOYER	WORK PHONE #	

EMPLOYER'S ADDRESS CITY STATE ZIP CODE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME	GROUP #
IF HMO/ PPO, Name of Primary Care Physician (PCP)	POLICY #
POLICY HOLDER (circle) PATIENT GUARANTOR	RELATIONSHIP TO PATIENT
ADDRESS	HOME PHONE #

SECONDARY INSURANCE COMPANY GROUP # POLICY #

PHARMACY INFORMATION:

PHARMACY NAME/ADDRESS/PHONE#

AUTHORIZATION INFORMATION: I authorize release of medical information to Medicare or other insurance companies pertaining to my history, services rendered or treatment given to me or my dependents for purposes of claims review. I request that Medicare or other insurance companies make payments on my behalf directly to <u>RHDO Physicians</u>. I am responsible for paying copayments at the time of service, if required by my insurance. I acknowledge and accept final responsibility for payment of all charges. I am advised that test sent to an outside laboratory may result in additional charges billed to me by the lab.

Signature _____ Date_____