Memorial Physicians, PLLC

Patient Registration

Patient Information

Please use your full name as it appears on your insurance or Medicare Card. No Nicknames.

Last Name__________________________________ First Name__________________________ MI ___________

Address____ City/State/Zip____

Home Phone____________ Work Phone____________ Cell Phone____________ Physician________________________

Birth Date_______________ Sex: M F Married Single Other Soc. Sec.#_________________________

Employer ____ Spouse's Name____

Emergency Contact____________________________________ Emergency Phone_____________________________________

Guarantor (Responsible for Account)

Last Name__________________________________ First Name__________________________ MI ___________

Address____ City/State/Zip____

Home Phone___________________________ Work Phone__________________________________

Birth Date_______________ Sex: M F Married Single Other Soc. Sec.#_________________________

☐ **Patient has no insurance, is private pay. Patient's Signature (Or Legal Guardian): Date:**

Insurance Information (COPY CARD(s) FRONT & BACK)

Primary Insurance Company____________________________________Subscriber ID_______________________________

Group ID______________________ Relationship to Patient____________________________ Effective Date_______________

Policy Holder's Name____ First_________________________ MI______________

Sex:M F Birth Date _________________ Home Phone________________________ Work Phone_______________________

Employer____ Co Pay $___________ Referral Needed? Y N

Secondary Insurance Company____________________________________Subscriber ID_______________________________

Group ID______________________ Relationship to Patient____________________________ Effective Date_______________

Policy Holder's Name____ First_________________________ MI______________

Sex:M F Birth Date _________________ Home Phone______________________ Work Phone_________________________

Employer____ Co Pay $___________ Referral Needed? Y N

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I authorize my insurance benefits (including Medicare) to be paid directly to Memorial Physicians, PLLC for services rendered. I also authorize Memorial Physicians, PLLC on behalf of __________________________ to release any information requested by the insurance company with regard to payment of benefits.

I _________________ the parent /legal guardian of _____________________ authorize & consent to routine & emergency medical services to be performed for my child when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

☐ **I authorize Memorial Physicians, PLLC or any collection agencies used by Memorial Physicians, PLLC to contact me by my cellular telephone for billing activities or payment arrangements.**

____ ____

Patient's Signature (Or Legal Guardian) Date Patient's Signature (Or Legal Guardian) Date

____ ____

Patient's Signature (Or Legal Guardian) Date Patient's Signature (Or Legal Guardian) Date