

PATIENT REGISTRATION FORM

MINOR & JAMES MEDICAL



(PATIENT LABEL HERE)

Patient Information

Last Name				First Name				MI	Alias or Maiden Name		
Date of Birth	Sex	Marital Status	Race	Social Security Number				Employer Name			
Street Address						Apt. #	City			State	Zip
Home Phone				Work Phone				Cell Phone			
Email Address				Emergency Contact Name & Relationship				Emergency Contact Phone #			

Responsible Party Information

Last Name				First Name				MI	Alias or Maiden Name		
Date of Birth	Sex	Marital Status	Race	Social Security Number				Relationship to the patient			
Street Address						Apt. #	City			State	Zip
Home Phone				Work Phone				Cell Phone			
Email Address				Employer Name				Occupation			

Insurance Information

Primary Insurance												
Insurance Company Name				Group Number				Subscriber ID Number			Copay	
Subscribers Name				Social Security Number				Date of Birth		Relationship to the patient		
Subscribers Employer Name				Subscribers Home Phone				Subscribers Work Phone				
Secondary Insurance												
Insurance Company Name				Group Number				Subscriber ID Number			Copay	
Subscribers Name				Social Security Number				Date of Birth		Relationship to the patient		
Subscribers Employer Name				Subscribers Home Phone				Subscribers Work Phone				

CONSENT TO CARE:

I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. _____ (Initial)

NOTIFICATION OF RELEASE FOR PAYMENT:

I understand that Minor and James Medical will disclose any diagnosis and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV/AIDS, sexually transmitted diseases, substance abuse, or mental health conditions. _____ (Initial)

FINANCIAL AGREEMENT:

I understand co-payments are due at the time of service. I assign payment from my insurance directly to Minor and James Medical. I understand I am financially responsible to Minor and James Medical for the charges not paid by insurance and that those charges are due within 30 days of invoice. I understand that in addition to the bill from my provider, I may also receive separate bills from the laboratory, radiology and other specialized services. _____ (Initial)

- Data entered into NextGen
- Insurance Card Scanned
- Drivers license/picture ID scanned

Patient Signature: _____

Parent or Guardian: _____

Date: _____