

1) PATIENT REGISTRATION

ACCT #:

DR. #:

DATE:

FIRST NAME	MIDDLE	LAST	BIRTH DATE	AGE
CIRCLE ONE: MR. MS MRS. MISS			SOCIAL SECURITY NO.	DRIVER'S LICENSE
STREET ADDRESS		CITY	STATE	ZIP
HOME PHONE	WORK PHONE	DATE OF ILLNESS OR INJURY		
MAY LEAVE MESSAGE WITH: <input type="checkbox"/> HOME ANSWERING MACHINE <input type="checkbox"/> WORK ANSWERING MACHINE <input type="checkbox"/> ANYONE ANSWERING HOME PHONE <input type="checkbox"/> ANYONE ANSWERING WORK PHONE <input type="checkbox"/> NONE				
EMPLOYER OR NAME OF SCHOOL		EMPLOYER ADDRESS		
SPOUSE'S NAME		SPOUSE'S EMPLOYER AND PHONE NUMBER		

2) PATIENT REFERRAL INFORMATION

REFERRED BY	PRIMARY MD	PHONE NUMBER
NAMES OF OTHER PHYSICIANS WHO CARE FOR YOU		

3) EMERGENCY CONTACT

NAME OF PERSON	RELATIONSHIP	WORK PHONE	HOME PHONE
STREET ADDRESS	CITY	STATE	ZIP

4) INDIVIDUAL RESPONSIBLE FOR PAYMENT

FIRST NAME	MIDDLE	LAST	RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD OTHER: _____	
HOME PHONE	WORK PHONE	CELL PHONE	SOCIAL SECURITY #	BIRTH DATE
STREET ADDRESS	APT. #	CITY	STATE	ZIP
EMPLOYER	PHONE NUMBER			
STREET ADDRESS	SUITE #	CITY	STATE	ZIP

5) PRIMARY INSURANCE COMPANY *Please present insurance card to the receptionist*

INSURANCE COMPANY NAME				
STREET ADDRESS	SUITE #	CITY	STATE	ZIP
NAME OF INSURED	BIRTH DATE	RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD OTHER: _____		
INSURANCE ID #	GROUP #	EFFECTIVE DATE		

6) SECONDARY INSURANCE COMPANY

INSURANCE COMPANY NAME				
STREET ADDRESS	SUITE #	CITY	STATE	ZIP
NAME OF INSURED	BIRTH DATE	RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD OTHER: _____		
INSURANCE ID #	GROUP #	EFFECTIVE DATE		

7) WORK RELATED INJURIES

NAME OF COMPENSATION INSURANCE CARRIER	ADJUSTER AND PHONE NUMBER	
CARRIER'S ADDRESS		
NAME OF EMPLOYER (AT TIME OF INJURY)	NAME OF SUPERVISOR AND PHONE NUMBER	
ADDRESS	DATE OF INJURY	
AUTHORIZATION GIVEN BY	NURSE CASE MANAGER	PHONE NUMBER
INDUSTRIAL CLAIM/CASE NUMBER	KAISER PHYSICIAN AND OFFICE	KAISER ID #

OVER - PLEASE COMPLETE BACK OF FORM

MEDICARE AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I request that payment of authorized Medicare benefits be made either to me or on my behalf to _____ for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the physician of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

Date

ASSIGNMENT OF BENEFITS • FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to _____, and my assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Beneficiary Signature

Date

Method of payment: Cash Check Credit Card

**Although the staff tries to stay abreast of all insurance information,
it is the patient's responsibility to review their handbook
and to know if they need a second opinion or pre-certification.**