Registration Form, Authorization for Treatment

PLEASE PRINT & FILL IN COMPLETELY

PATIENT'S NAME____ AGE:__________ SEX:__________
First **M.1.** **Last**

(Circle One)

DateBirth____________________ Social Security#____________________ Single Married Widowed Divorced Separated

Address______________________________ Apt# ________ City______________ State_____ ZipCode____________

Phone# ____(____)________________ E-MAIL Address (Optional)____

Employer ____ Work, Phone ____(____)________________

IF PATIENT IS A CHILD, PLEASE GIVE BOTH PARENTS INFORMATION BELOW
IF PATIENT IS MARRIED PLEASE FILL IN SPOUS INFORMATION

SPOUSE OR FATHER________________________________ Date of Birth__________ Social Security#____________

Address (if different from above)____________________________ City & State__________________ ZipCode_________

Home Phone#_____(____)____________ Work Phone#_____(____)______________ Employer____________________

MOTHER____ Date of Birth__________ Social Security#____________

Address (if different from above)____________________________ City & State__________________ ZipCode_________

Home Phone#_____(____)____________ Work Phone#_____(____)______________ Employer____________________

EMERGENCY
CONTACT:____ Phone#________________ Relationship_____________

Primary Insurance Carrier______________________________ Policy Holder__________________________________

Secondary Insurance Carrier____________________________ Policy Holder__________________________________

PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST FOR PHOTOCOPYING
IF THIS IS A WORK RELATED INJURY PLEASE NOTIFY THE RECEPTIONIST

AUTHORIZATION FOR TREATMENT & ASSIGNMENT OF INSURANCE BENEFITS

* I hereby give permission to the Medical Center of Stafford, P.C. to render care. I understand the policy of the Medical Center of Stafford, have been given a copy of this information and accept full financial responsibility for all charges incurred on behave of the above patient.
* I authorize the Medical Center of Stafford to apply for benefits on my behalf for COVERED services rendered me and request payment be made by my insurance company to the Medical Center of Stafford for ANY BALANCE NOT PAID AT THE TIME OF SERVICE.
* I certify the information reported with regard to my insurance coverage is correct and authorize the release of any necessary information to my insurance carrier or named billing agent (or in case of Medicare benefits, HCFA) in order to determine insurance benefits to which I am entitled.

Whom may we talk to regarding your health care? :____

Whom may we talk to regarding your financial status? :____

Signature Patient/Guardian________________________________ **Date**__________________________________

Check out our Web site at : WWW.STAFFORDMEDICAL.COM