Carondelet Medical Group. Be well.

PATIENT REGISTRATION FORM

(Please Print)

Today's Date:	Personal Physician:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.: ( ) Cell Phone no.: ( )	**Race:** ☐ Asian ☐ Black ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Pacific Islanders ☐ Not Reported/Refused **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Not Reported/Refused

PO Box:	City:	State:	ZIP Code: -

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Other family members seen here
(Name & Date of Birth):

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Name of Primary insurance:

Policy Holder's name:	Policy Holder's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to policy holder:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Policy Holder's name:	Group no.:	Policy no.:

Patient's relationship to policy holder:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

ADVANCE DIRECTIVES

Does patient have a Living Will?	☐ Yes	☐ No	If Yes, where is document kept?
Does patient have Healthcare Power of Attorney?	☐ Yes	☐ No	If Yes, where is document kept?

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs. It is agreed that payments will not be delayed or withheld because of insurance coverage. All payments of insurance are assigned to this office (a copy of the assignment is as valid as the original). I authorize release of any medical information necessary to process claims.

☐ **I have received a copy of Carondelet Medical Group's "Notice of Privacy Practices".**

Patient/Guardian Signature *Date*