Post Rock Family Medicine Patient Registration Form

PATIENT INFORMATION

Patient Name (first, middle, last)		SSN
Date of Birth	Marital Status	Referred By
Address	City/State	Zip
Home Phone	Cell Phone	Email
Race	Ethnic Group	Preferred Language
Responsible Party		Relationship
Responsible Party Address		
Emergency Contact	Phone	Relationship

PATIENT EMPLOYER INFORMATION

Occupation		
Employer		Phone
Address	City/State	Zip

INSURED INFORMATION (if not patient)

Name	Phone	Date of Birth
Address	City/State	Zip
Relationship to Patient		Employer

INSURANCE INFORMATION

Primary Insurance Name	Phone
ID Number	Group Number
Secondary Insurance Name	Phone
ID Number	Group Number
Medicaid Number (if applicable)	
Medicare Number (if applicable)	

Authorization to Release Information and Assignment of Benefit

By signing this form, I understand the following statements:

1) I hereby authorize payment directly to the medical provider of benefits due me for the services rendered by Daniel J. Sanchez, MD, PA, Prairie Star Family Practice, PA, LifeLine Family Medicine, PA, Rooks County Health Center Clinic or Solomon Valley Family Medicine, PA. I understand that I am responsible for charges not covered by this authorization. I hereby authorize the release of any information regarding my examination to my insurance company, workman's compensation, laboratory or radiology for billing reasons.
2) I understand that there may be times when my health care provider orders tests that my insurance may deem unnecessary. I agree to be responsible for these charges.
3) I understand that laboratory and radiology (x-ray) charges are separate from the health care provider's visit. Any questions I have about laboratory and radiology billing should be addressed directly with that facility. I agree to be responsible for the charges billed by the laboratory and radiology providers.

Date Signature