

# REGISTRATION FORM

## ACCOUNT INFORMATION

Responsible Party Name:		
Address:		
City:	State:	Zip code:
Telephone:		

## PATIENT INFORMATION

Patient's Name:		
Address:		
City:	State:	Zip Code:
Home Phone:	Mobile Phone:	
Emergency Phone:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth:	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other		
Social Security Number:	Primary Care Doctor:	
E-Mail address:		
Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Student		
Employer Name:		
Employer Address:		
City:	State:	Zip Code:
Employer Telephone:		
How did you hear about us? <input type="checkbox"/> Radio <input type="checkbox"/> Newspaper <input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Doctor Referral <input type="checkbox"/> Relative/Friend <input type="checkbox"/> Other (Please Specify):		

Emergency Contact Name:	
Relationship to Patient:	Emergency Phone:

## AUTHORIZATION FOR TREATMENT & ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to Pinehurst Medical Clinic for any services furnished me by the party/physician who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company or a related Medical claim. I permit a copy of this authorization to be used in place of the original.

I, the Patient/patient's legal representative, hereby grant permission to the Pinehurst Medical Clinic and its authorized representatives to perform examinations/treatment deemed necessary or advisable for my/the patient's diagnosis and treatment.

Signature

Date

**PATIENT INSURANCE INFORMATION**

✓ Please check if your visit involves:    Workers Comp    Auto Accident

**PRIMARY INSURANCE**

<b>Insurance Company:</b>		
<b>Group Number:</b>	<b>Policy Number:</b>	
<b>Effective Date – From:</b>		
<b>Subscriber name:</b>	<b>Patient’s Relationship to Insured:</b>	
<b>Street address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Phone:</b>	<b>Subscriber’s DOB:</b>	
<b>Subscriber SSN:</b>	<b>Subscriber’s Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Subscriber Employer:</b>		
<b>Employer Address:</b>		
<b>Employer City:</b>	<b>Employer State:</b>	<b>Employer Zip Code:</b>
<b>Employer Phone:</b>		

**SECONDARY INSURANCE**

<b>Insurance Company:</b>		
<b>Group Number:</b>	<b>Policy number:</b>	
<b>Effective Date – From:</b>		
<b>Subscriber Name:</b>	<b>Patient’s Relationship to Insured:</b>	
<b>Street address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Phone:</b>	<b>Subscriber DOB:</b>	
<b>Subscriber SSN:</b>	<b>Subscriber Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Subscriber Employer:</b>		
<b>Employer Address:</b>		
<b>Employer City:</b>	<b>Employer State:</b>	<b>Employer Zip Code:</b>
<b>Employer Phone:</b>		

**TERTIARY INSURANCE**

<b>Insurance Company:</b>		
<b>Group number:</b>	<b>Policy Number:</b>	
<b>Effective Date – From:</b>		
<b>Subscriber Name:</b>	<b>Patient’s Relationship to Insured:</b>	
<b>Street Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Phone:</b>	<b>Subscriber’s DOB:</b>	
<b>Subscriber SSN:</b>	<b>Subscriber Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Subscriber Employer:</b>		
<b>Employer Address:</b>		
<b>Employer City:</b>	<b>Employer State:</b>	<b>Employer Zip Code:</b>
<b>Employer Phone:</b>		

