Patient Registration

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____

Street Address: _____Apt. number_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Social Security No.:_____

Cell Phone: _____

Email (where I can privately send you results): _____

Sex: ❑ Male ❑ Female Date of Birth: _____

Name of Employer: _____ Work Phone: _____

Work Address: _____

Marital Status:

❑ Single ❑ Widowed ❑ Separated ❑ Divorced

❑ Married; Spouse's name: _____

❑ Partnered; Partner's name: _____

Who referred you to our office? _____

IN CASE OF EMERGENCY

Please call: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

What is the name of your insurance company? _____

ID number on insurance card: _____

Name and relation of insurance holder (eg. self, spouse, parent, etc.): _____

Insurance holder's date of birth (If not yourself): _____
Do you have a second insurance company? If so, what? _____

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to East Side Medical Practice, PC and its physicians for any services furnished me by the doctor(s) or their designees. I understand that I will be responsible for any deductibles, co-payments and non-covered services. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services, and to any party performing services of medical receivables on behalf of the doctor's office.

Signature of Patient: _____Date:_____