Palms Medical Group
Your home for health, wellness, life

PATIENT REGISTRATION

All Information is Required and Confidential

Account Number: _____ **DATE: _____**
ALERGIES:

PATIENT INFORMATION (Additional)

LAST Name: _____ FIRST: _____ MI: _____

Driver's License Number and State: _____

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Race: [ ] Black [ ] Caucasian [ ] Hispanic [ ] Other

Approximate Household Income*: $_____ Annual [ ] Monthly [ ] Weekly [ ]
Number of People in Household: _____
*** This is strictly confidential information and is used solely for Trenton Medical Center, Inc's benefit.

MUST CHECK ONE: [ ] Migrant Worker [ ] Seasonal Worker [ ] Not Applicable

IF PATIENT IS A CHILD LIST PARENT INFORMATION HERE

LAST NAME: _____ FIRST: _____ SS#: _____
Mailing Address: _____Date of Birth: _____
Relationship to the Child: _____ Driver's License #: _____
Home PH# ( ) Work PH# ( )

INSURANCE

Insurance: _____ Policy Number:_____

A COPY OF YOUR CARD MUST BE ON FILE BEFORE WE BILL YOUR INSURANCE COMPANY.

EMERGENCY CONTACT: _____PHONE: _____

I authorize Trenton Medical Center, Inc. Staff and/or whomever they may delegate to provide medical, nursing, emergency care or such treatment as necessary.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered including any lab or x-ray procedures which may not be covered by insurance or under Medicare. I further authorize the release of any medical information necessary to process my claim. I also request payment of government benefits such as Medicare and Champus or my insurance company to Trenton Medical Center, Inc.

I certify that this information is true and correct to the best of my knowledge. I will notify you of any change in my health status or the above information.

_____

Lifetime Signature of Patient, Parent, or Legal Guardian **Date**