I-70 Medical Clinic
REGISTRATION FORM
(Please Print and fill out completely)

Today's Date:	Primary Care Physician:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.
Birth date:	Age:	Gender:	Social Security No.:	Marital Status:
Home Phone Number:	Work Phone Number:	Cell Phone Number:		
Street Address:	City:	State:	Zip Code:	
P.O. Box:	County:	Ethnicity: (Circle One) Hispanic Non Hispanic	Race:	
Occupation:	Employer:	Employer phone number:		

RESPONSIBLE PARTY

Person responsible for bill:	Birth date:	Address (if different):	Phone Number:
Occupation:	Employer:	Employer address:	Employer Phone Number:

INSURANCE INFORMATION

Is this patient covered by insurance? (Circle One) Yes No (Please give your insurance card to the receptionist)

Name of Primary Insurance:	Subscriber's Name:	Subscriber's S.S No.:	Subscriber's Birth date:	Gender:
Patient's relationship to Subscriber: (Circle One) Self Spouse Child Other	Employer:			
Name of Secondary Insurance (if applicable):	Subscriber's Name:	Subscriber's S. S. No.:	Birth date:	
Patient's relationship to Subscriber: (Circle One) Self Spouse Child Other	Gender:	Employer:		

IN CASE OF EMERGENCY CONTACT INFORMATION

Name:	Relationship to patient:	Phone Number:

HIPAA CONTACT INFORMATION

I give my permission for the physicians and staff at I-70 Medical Clinic to share my confidential information with the following persons. I have received or I have been provided the opportunity to receive a copy of the *Notice of Privacy Practices* that explains when, where, and why my confidential health information may be used or shared.

Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the I-70 Medical Clinic. I understand that I am financially responsible for any balance due after insurance correspondences have been received, if applicable to bill an insurance company. If no insurance information is provided I understand that I am responsible for the entire bill. I authorize I-70 Medical Clinic or my insurance company to release any information required to process my claims. My signature below is an indicator of my consent to treatment at I-70 Medical Clinic, unless specific consent is otherwise needed for invasive procedures. This consent form and signature is valid for 12 months following signature date, unless specifically terminated.

Patient/Guardian Signature	*Date*