MAPLE MEDICAL, ™LLP

Pulmonary, Critical Care, Internal Medicine, Endocrinology, Cardiology, Nephrology & Gastroenterology

PATIENT REGISTRATION FORM

PATIENT INFO

FIRST/MIDDLE/LAST NAME			
HOME ADDRESS			
EMAIL ADDRESS			
HOME PHONE #		**WORK PHONE #**	**MOBILE PHONE #**
LANGUAGE	**DOB**	**SOCIAL SECURITY #**	**MARITAL STATUS**
PRIMARY CARE PHYSICIAN		**EMPLOYER**	
EMERGENCY CONTACT		**EMERGENCY PHONE #**	
PHARMACY NAME		**PHARMACY ADDRESS & PHONE#**	

RESPONSIBLE

PERSON RESPONSIBLE FOR PAYMENT IF PATIENT IS UNDER AGE 18		
FIRST/MIDDLE/LAST NAME		
STREET ADDRESS		
HOME PHONE #	**DOB**	**SOCIAL SECURITY #**
EMPLOYER NAME	**EMPLOYER PHONE #**	

INSURANCE INFO

PRIMARY INSURANCE			
PRIMARY INSURANCE NAME		**PRIMARY INSURANCE ADDRESS**	
SUBSCRIBER NAME		**DOB**	**SEX**
SUBSCRIBER ID #	**GROUP #**		**RELATION TO PATIENT**
SECONDARY INSURANCE			
SECONDARY INSURANCE NAME		**SECONDARY INSURANCE ADDRESS**	
SUBSCRIBER NAME		**DOB**	**SUBSCRIBER NAME**
SUBSCRIBER ID #	**GROUP #**		**SUBSCRIBER ID #**

RELEASE

I understand and accept that I will be financially responsible for all deductibles, co-payments, co-insurances, and non-covered charges as provided by my insurance plan. If I fail to cancel my appointment without at least 24 hours prior notice, a fee will be charged. If my insurance plan requires a valid referral to receive medical care, I understand that it is my responsibility to provide such referral. If my referral is determined to be invalid by my insurance carrier, I understand that I will be financially responsible for balances on my account including non-covered items. If my insurance plan is not accepted by this office or is of the indemnity type, I understand that I am financially responsible for all balances remaining after payment, if any, made by my insurance plan. I hereby authorize and assign directly to Maple Medical, LLP, all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the physician and/or their representative(s) to release any and all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Patient Signature: _____ Date: _____