Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ Change	Info. Change:

Patient Registration Form

Please complete this form in order to ensure proper billing of your services. **Please Print.** **Today's Date:** ________

Patient Last Name: ________
First Name: ________ MI ________
Other Name: ________
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other
Addr1: ________
Addr2: ________
City, State, Zip: ________
Driver's License # (DL#) ________ State(ST) ________
Emp. Status: ☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed ☐ Disabled ☐ Homemaker ☐ Student ☐ Active Military ☐ Self-Employed ☐ Other ____

Social Security Number: ________
Date of Birth: ________ Sex: ☐ M ☐ F
Race: **(Response is not mandatory. Data is used for statistical reporting.)**
☐ African American ☐ Asian/Oriental ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other ☐ Unknown
Home Phone: (____) ________
Alt Phone: (____) ________
Home E-Mail: ________
Cell Phone: (____) ________
Employer: ________
Address: ________
City, State, Zip: ________
Work Phone : (____) ________

Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)

Guarantor: ________
Addr1: ________
Addr2: ________
City, State, Zip: ________
Employer: ________
Address: ________
Work Phone: (____) ________
Driver's License # (DL#) ________ State(ST) ________

Patient's Relationship to Guarantor: ________
Social Security Number: ________
Date of Birth: ________ Sex: ☐ M ☐ F
Home Phone: (____) ________
Cell Phone: (____) ________
City, State, Zip: ________
Guarantor E-Mail: ________

Emerg. Cont.: ________
Home Phone: (____) ________
Alt Phone: (____) ________

Patient's Relationship to Emerg. Cont.: ________
Cell Phone: (____) ________

How did you hear about our practice? ☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ Mass Mailing ☐ Newspaper/Magazine ☐ Ongoing Care ☐ Patient ☐ Phone Book ☐ Phys. Off/ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth ☐ Other

INSURANCE INFORMATION (A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRIER: ________
Address: ________
Group/Plan #: ________ Effective Date: ________
Subscriber's DOB: ________ SSN: ________ Sex: ☐ M ☐ F

Telephone #: (____) ________
ID/Cert #: ________
Subscriber's Name: ________
Relationship to Patient: ________

SECONDARY CARRIER: ________
Address: ________
Group/Plan #: ________ Effective Date: ________
Subscriber's DOB: ________ SSN: ________ Sex: ☐ M ☐ F

Telephone #: (____) ________
ID/Cert #: ________
Subscriber's Name: ________
Relationship to Patient: ________

PCP: ________
Address: ________
City, St., Zip: ________
Telephone #: ________

Refer. Phys. (if different): ________
Address: ________
City, St., Zip: ________
Telephone #: ________

Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ Change	Info. Change:

Child/Dependent Registration Form

Please complete this form in order to ensure proper billing of your services. **Please Print.** **Today's Date:**________________________

Patient Last Name: ____

First Name: __________________________________ MI ______

Other Name: ____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other

Addr1: ____

Addr2: ____

City, State, Zip: ____________________________________

Driver's License # (DL#) ____________________ State(ST) ______

Social Security Number: __________________________________

Date of Birth: ________________________ Sex: ☐ M ☐ F

Race: **(Response is not mandatory. Data is used for statistical reporting.)**

☐ African American ☐ Asian/Oriental ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other ☐ Unknown

Home Phone: (______) ____________________________

Daytime Phone: (______) ____________________________

Emp. Status: ☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed ☐ Disabled ☐ Homemaker ☐ Student ☐ Active Military ☐ Self-Employed ☐ Other ________

INSURANCE INFORMATION (A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRIER: ____________________________________

Address: ____

Group/Plan #: ________________ Effective Date: __________

Subscriber's DOB: _________ SSN: ___________ Sex: ☐ M ☐ F

Telephone #: (______) ____________________________

ID/Cert #: ____________________________________

Subscriber's Name: ______________________________

Relationship to Patient: ____________________________

SECONDARY CARRIER: __________________________________

Address: ____

Group/Plan #: ________________ Effective Date: __________

Subscriber's DOB: _________ SSN: ___________ Sex: ☐ M ☐ F

Telephone #: (______) ____________________________

ID/Cert #: ____________________________________

Subscriber's Name: ______________________________

Relationship to Patient: ____________________________

PCP: ____

Address: ____

City, State, Zip: ____________________________________

Telephone #: ____________________________________

Refer. Phys. (if different): ____________________________

Address: ____

City, State, Zip: ____________________________________

Telephone #: ____________________________________

Parent/Guardian Information

Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)

Guarantor: ______________________

Addr1: ______________________

Addr2: ______________________

City, State, Zip: ______________________

Employer: ______________________

Address: ______________________

Driver's License # (DL#) ______________ State(ST) _______

Patient's Relationship to Guarantor: ______________________

Social Security Number: ______________________

Date of Birth: ______________________ Sex: ☐ M ☐ F

Home Phone: (_______) ______________________

Work Phone: (________) ______________________

City, State, Zip: ______________________

Emerg. Cont.: ______________________

Addr1: ______________________

Addr2: ______________________

City, State, Zip: ______________________

Patient's Relationship to Emerg. Cont.: ______________________

Home Phone: (_______) ______________________

Work Phone: (_______) ______________________

How did you hear about our practice? ☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ Mass Mailing ☐ Newspaper/Magazine ☐ Ongoing Care ☐ Patient ☐ Phone Book ☐ Phys. Off/ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth ☐ Other

List All Children/Siblings

Child#1 Last Name	First Name	Date of Birth
Child#2 Last Name	First Name	Date of Birth
Child#3 Last Name	First Name	Date of Birth
Child#4 Last Name	First Name	Date of Birth

IDX Account #: ____________________

Advocare Signature on File Form

Medicare (if applicable)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Advocare and/or the individual Attending Physician, for any services furnished to me by that Physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	☐ Y ☐ N	Has treatment been authorized by the V.A.?	☐ Y ☐ N
Do you or your spouse have other insurance?	☐ Y ☐ N	Are you covered under the Black Lung Program?	☐ Y ☐ N
Are you disabled or have end stage renal disease?	☐ Y ☐ N	Is there Medigap coverage secondary to Medicare?	☐ Y ☐ N
Is illness/injury the result of an auto accident?	☐ Y ☐ N	Is there insurance coverage primary to Medicare?	☐ Y ☐ N
Did illness/injury occur at work?	☐ Y ☐ N	Is there employer supplemental coverage secondary to Medicare?	☐ Y ☐ N

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

Assignment of Benefits/Authorization/Notice of Collection Action

I request payment of insurance benefits for all services rendered to me or to my child/children to be made on our behalf to Advocare. I authorize Advocare to release medical information to my insurance carrier and its entities to determine payment for services rendered. I further understand I am responsible to pay certain amounts due. These amounts may include annual deductibles, co payments, charges denied by my insurance company as not covered or not medically necessary. I am responsible for any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). Please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing.

The undersigned certifies that each has read and understands the above terms and conditions.

____
Patient Name (Please Print)

X____
Patient Signature Date

X____
Patient's Agent Representative and Guarantor Signature Date