WHITE HALL FAMILY MEDICINE * NEW PATIENT REGISTRATION

PATIENT NAME _______________ DATE OF BIRTH _______________

SEX M F

SOCIAL SECURITY NUMBER _______________

RACE _______________

MAILING ADDRESS _______________

MARITAL STATUS S M W D

TELEPHONE HOME _______________ WORK _______________ CELL _______________

EMPLOYER _______________

CONTACT & TELEPHONE NUMBER FOR EMPLOYER'S BENEFIT INFORM _______________

EMAIL ADDRESS _______________

PHARMACY _______________

SPOUSE'S NAME _______________

SPOUSE'S EMPLOYER & TELEPHONE NUMBER _______________

PARENT/GUARDIAN (IF UNDER 18) _______________

PARENT/GUARDIAN EMPOYER _______________

EMERGENCY CONTACT (OUTSIDE THE HOME) NAME AND TELEPHONE NUMBERS

1 _______________ CELL # _______________ OTHER # _______________

2 _______________ CELL # _______________ OTHER # _______________

PRIMARY INSURANCE	SECONDARY INSURANCE
COMPANY	COMPANY
ADDRESS ID	ADDRESS ID
NUMBER	NUMBER
GROUP NUMBER	GROUP NUMBER
INSURED NAME (AS IT APPEARS ON CARD)	INSURED NAME (AS IT APPEARS ON CARD)
SOCIAL SECURITY NUMBER	SOCIAL SECURITY NUMBER
INSURED'S DATE OF BIRTH	INSURED'S DATE OF BIRTH

PAYMENT REQUIRED AT THE TIME OF CHECK IN -UNLESS PRIOR ARRANGEMENTS HAVE BEEN IN ADVANCE. ALL INSURANCE CARDS ARE REQUIRED AT TIME OF CHECK IN

ASSIGNMENT OF INSURANCE BENEFITS

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance.

I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL / SURGICAL BENEFITS TO MARK RAMIRO, MD / DOUG COLEMAN, MD, FOR SERVICES RENDERED BY HIM IN PERSON OR UNDER HIS SUPERVISION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE.

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE MARK RAMIRO, MD, / DOUG COLEMAN, MD, TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATON THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATION FOR FINANCIAL BENEFIT.

MEDICARE / MEDICAID

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT IS CORRECT. I AUTHORIZE RELEASE OF ALL RECORDS ON REQUEST. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF

A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE VALID AS THE ORIGINAL

______________________________________ ________

PATIENT NAME (PLEASE PRINT) DATE

______________________________________ ________

PARENT/GUARDIAN (PLEASE PRINT) DATE

____

SIGNATURE PATIENT, PARENT OR GUARDIAN

Who referred you to our clinic

In order to control your cost of billings, we request that our charges for office visits be paid at time of check in for each visit.

You need the following when you check in
1. insurance cards
2. list of all medicines you are taking, prescription and over the counter
3. be prepared to pay all co-pays and deductibles

Your Appointment date___________________________Appointment Time _____________________

White Hall Family Medicine

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