

PATIENT REGISTRATION

DATE _____

DRUG ALLERGIES _____

Patient Name: _____
(Last) (First) (Middle)

Date of Birth _____ Age _____ Birthplace _____ Social Security # _____

Marital Status: S M D W Sex: M F Race: W B A I H Other _____ Email _____

Address _____ Apt _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Employer _____ Occupation _____

Employer Address _____

Who is financially responsible for this patient? Self Other _____

Family Members Seen Here _____

Who referred you to our office ? _____

Spouse/Parent Name _____ Age _____ Occupation _____

Employer _____ Business Phone _____

Employer Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Relationship _____ Phone _____

Insurance Information: Please complete with primary insurance holder's information.

PRIMARY INSURANCE

Insured _____ Relationship to Patient _____

Date of Birth _____ Home Phone _____ Work Phone _____

Insurance ID # _____ Group Number _____ Social Security # _____

Employer _____ Insurance Plan Name _____ PPO HMO POS HSA

SECONDARY INSURANCE

Insured _____ Relationship to Patient _____

Date of Birth _____ Home Phone _____ Work Phone _____

Insurance ID# _____ Group Number _____ Social Security # _____

Employer _____ Insurance Plan Name _____ PPO HMO POS HSA

I authorize John E. West, M.D., P.C. to release any information necessary to process medical insurance claims, to authorize referrals to specialists approved by Dr. West, to assist in my treatment from specialists/facilities/emergency care I have been referred to by Dr. West. This includes information of a psychiatric nature, drug or alcohol abuse, pregnancy, and HIV.

Patient/Guardian Signature Date

I assign payment to John E. West, M.D., P.C. specified under the terms of my insurance contract. I understand the Practice will file my insurance coverage with a current, valid insurance card for plans the Practice is contracted with. I understand I am responsible for any co-pays, coinsurances, deductibles, and non-covered services at the time of service. I will be responsible for providing insurance information and verifying current personal address information at each visit. At the time of service I will be responsible for all charges if I do not present valid insurance information. John E. West, M.D., P.C. cannot guarantee insurance benefits. It is the patient's responsibility to be aware of what their plan will cover. Delinquent accounts may be forwarded to a collection service after 90 days and the patient dismissed from the practice. The Practice will work with hardship cases on a individual basis. Notify the Business Manager if a payment arrangement is needed prior to services being provided.

Patient/Guardian Signature Date