

StatCare Clinic Registration

PATIENT INFORMATION

Name: _____ Date of Birth: ____/____/____ Age: ____ Sex ____
Last First MI

SSN: _____ Home Phone: (____) _____

Your Address: _____ Your Cell #:(____) _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Work Phone :(____) _____

Primary MD: _____ Clinic/city: _____

Occupation: _____ Referred by: _____

Spouse's Name: _____ Cell #/Work# _____

Privacy statement: The privacy of your medical record is protected by state and federal law; no personal data may be released to another party without your written consent, unless required for law enforcement purposes.

INSURANCE INFORMATION

PRIMARY: _____

Subscriber Name: _____ Policy #: _____ Group # _____

Subscriber DOB: _____ Subscriber SSN: _____

Relation to Patient: _____ Subscriber Employer: _____

SECONDARY INSURANCE: _____

Subscriber Name: _____ Policy #: _____ Group # _____

Subscriber DOB: _____ Subscriber SSN: _____

Relation to Patient: _____ Subscriber Employer: _____

I authorize my insurance benefits to be paid directly to the physician, and I acknowledge I am financially responsible for all charges not covered by my insurance, including any copays or deductibles, and goods or services provided by StatCare but not covered by my insurance. I hereby consent to the release of my medical record to my insurance company and/or Medicare and its authorized subcontractors, including any and all psychiatric, alcohol or drug abuse records, HIV or other STD results as needed to permit StatCare to file medical claims on my behalf.

I agree to promptly pay for the services rendered for me or the patient named above. If I fail to meet my financial commitment to StatCare and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees, and a \$25 fee for every NSF check. I further agree to pay for any missed appointments for which I did not provide at least 4 hours notice, except in case of genuine emergency or incapacity due to illness.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:

Signed _____ Date: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation to Patient: _____

Home Phone: (____) _____ Work Phone : (____) _____