

REGISTRATION FORM

(Please print)

PRIMARY CARE PHYSICIAN: _____ PHARMACY: _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Sex: Male _____ Female _____ SSN: _____ Marital Status: M S D W

Home Phone: _____ Work Phone: _____ Cell: _____

E-mail: _____ Primary Language: _____

Preferred Communications: Phone _____ E-mail _____ Ethnicity: Hispanic _____ Non-Hispanic _____

Race: Asian _____ Black or African American _____ White _____ American Indian _____ or Other _____

Parent/Guardian:

Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

PATIENT EMPLOYER INFORMATION:

Employer Name: _____ Occupation: _____ Phone: _____

WAS VISIT RELATED TO THE FOLLOWING:

Auto accident: Y N Workers' Compensation: Y N Other Accident: Y N

EXPLAIN: _____

INSURANCE INFORMATION:

PRIMARY:

Please indicate primary insurance _____ BC/BS _____ Cigna _____ United Healthcare _____ Connecticare _____ Medicare
_____ Oxford _____ Tricare _____ CHN _____ XIX _____ Other if other please list: _____

Subscriber's name: _____ DOB: _____ ID#: _____ Grp #: _____

Relationship to Patient: _____ Employer Name: _____

SECONDARY:

Please indicate secondary insurance _____ BC/BS _____ Cigna _____ United Healthcare _____ Connecticare _____ Medicare
_____ Oxford _____ Tricare _____ CHN _____ XIX _____ Other if other please list: _____

Subscriber's name: _____ DOB: _____ ID#: _____ Grp #: _____

Relationship to Patient: _____ Employer Name: _____

PLEASE COMPLETE OTHER SIDE:

Patient Name: _____

Date: _____

I give permission to discuss my medical condition, diagnosis and financial account with:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

IN CASE OF EMERGENCY:

Emergency contact: Name: _____ Relationship: _____ Phone #: _____

ASSIGNMENT OF BENEFITS

(Please read carefully and sign and date where indicated)

ASSIGNMENT OF BENEFITS: I hereby assign medical and/or surgical benefits, to which I am entitled to: ECENT. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

PROTECTED HEALTH INFORMATION (PHI): I GIVE PERMISSION TO ECENT TO FOLLOW MY INSTRUCTIONS SHOWN BELOW REGARDING MY PHI: The following PHI will remain in effect until revoked or revised by me in writing.

- Confirm appointments and/or leave messages at ____ home / ____ work via person, answering machine.
- I acknowledge receipt of ECENT's Notice of Privacy:
- Patient declined ECENT's Notice of Privacy: _____ ECENT Initials.

I hereby acknowledge that I have read and understand the above.

Patient Signature:

_____ Date: _____ Witness: _____