

REGISTRATION/UPDATE INFORMATION:

Date: _____

Patient: _____

Street Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Age _____ Birth date: ____/____/____ M F

Single Married Widowed Divorced

Patient Employed By: _____ Occupation: _____

Employer Address: _____ State: _____ Zip: _____

Spouse (or Guardian) Name: _____

Employed By: _____

Business Address: _____ State: _____ Zip: _____

PRIMARY INSURANCE CO.: _____

SECONDARY INSURANCE CO.: _____

ID# _____

ID# _____

Plan or Group# _____

Plan or Group# _____

Insured _____

Insured _____

DOB: _____ Social Security No. _____

DOB: _____ Social Security No. _____

In Case of Emergency, who should be notified? _____ Phone _____

Who may we thank for referring you? _____

Who else may we discuss your medical care or appointment time with? _____

Preferred Local Pharmacy Name: _____ Address: _____

Pharmacy Phone Number _____ Do you utilize a mail order pharmacy? Yes No

Name of mail order pharmacy: _____ Id # _____

PLEASE READ AND SIGN BELOW

I hereby assign all medical and/or surgical benefits to which I am entitled, including private insurance, Medicare and other health plans to Stella Maris Internal Medicine.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges incurred. I hereby authorize said assignee to release all information necessary to secure the payment.

I agree that ultimately I am responsible for any remaining balance that my insurance company does not pay minus any contracted adjustments and/or discounts.

In addition to the foregoing, I hereby authorize the release of my medical information by or between any of my treating physicians and my insurer, HMO, health benefits payer or any other entity (including by not limited to third party administrators, management companies and provider networks) involved in the administration of my health benefits.

Signature: _____ Date: _____