



PATIENT REGISTRATION

Welcome to our clinic. In order to serve you properly, we will need the following information. (Please Print)
 All information will be strictly confidential.

Patient's Name		Sex M F	Birth Date ___/___/___ Age _____	Marital Status Single [] Married [] Widowed [] Divorced []	
Residence address		City	State	Zip	Home Phone
Person financially responsible for this account		Self Spouse	Responsible Party's Birth Date ___/___/___		Responsible Party's Social Security#
Responsible Party Driver License#	State:	Number:		Occupation	How long at current Employer?
Name of employer			Address or ___ Not Applicable		Business Phone
Reason for Visit:			Referred by: (include address and phone)		
Person to contact in case of emergency:			Relationship to patient	Phone	
Medicare Yes [] No []	Medicare#		Medicaid Yes [] No []	Medicaid#	Effective Date
Medicare Secondary insurance name			Address		Policy#
Group#		Worker's Compensation? Yes [] No []		Motor Vehicle? Yes [] No []	Date of Accident
Treatment authorized by		Claim#		W/C or MVA Insurance Phone#	
Primary insurance company			Address		Is Insurance through your employer?
Subscriber Name		Subscriber birth date		Policy#	Group#
Secondary insurance name			Address		Policy#
Group#			Lifetime Assignment of Benefits/		

Information Release / Authorization to Treat:

I authorize payment of medical benefits to Alexandria Healthcare Center for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my Insurance company or its agent information concerning health care, advise, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatment or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

I have received a copy of my Patient Rights and Responsibilities and this facility's Grievance Procedure.

 Patient, Parent or Guardian Signature (if child is under 18 years old)

 Date