Patient Registration Information

Please PRINT AND Complete ALL Sections Below!

PATIENT'S PERSONAL INFORAMTION **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: ____ ____________________________________ _____________

Last Name First Name Initial

Date of Birth: _______ / _______ / _______ Social Security #: ________ - _______ - ________

Home Phone: (____)___________________ Work Phone: (____)___________________ Cell Phone: (____) __________________

Address: _______________________________________ Apt. #: ____City: _________________ State: ____ Zip: ____________

Email: ____

PATIENT'S/RESPONSIBLE PARTY INFORMATION Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name: ____ ____________________________________ _____________

Last Name First Name Initial

Date of Birth: _______ / _______ / _______ Social Security #: ________ - ________ - ________

Home Phone: (____)___________________ Work Phone: (____)____________________ Cell Phone: (____) _________________

Address: ____ Apt. #: ______City: ________________ State: _____ Zip: _______

PATIENT'S INSURANCE INFORMATION ***(Please present insurance cards to receptionist)***

PRIMARY Insurance Name: ____

Address: ____City: ______________ State: _____ Zip: ____________

Name of insured: __________________________________ Date of Birth: ___________ Relationship to insured: _____________

Policy #: ________________________________ Group #: ____________________ Copay: $_____________

SECONDARY Insurance Name: ____

Address: ____City: ______________ State: _____ Zip: ____________

Name of insured: __________________________________ Date of Birth: ___________ Relationship to insured: _____________

Policy #: ________________________________ Group #: ____________________ Copay: $_____________

PATIENT'S REFERRAL INFORMATION

Name: ____

Address: ____ City: ___________________ State: _____ Zip: ____________

Phone: (_____)____ Fax: (_____)____

PHARMACY INFORMATION

Name: ____

Address: ____ City: ___________________ State: _____ Zip: ____________

Phone: (_____)____ Fax: (_____)____

EMERGENCY CONTACT

Name: ____

Address: ____ City: ___________________ State: _____ Zip: ___________

Phone: (_____)____ Fax: (_____)____

Assignment of Benefits/Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to Internal Medicine Physicians Associates, P.C. and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original.

Date: ____________________________ Your Signature: ____