

## CLARKSTON INTERNAL MEDICINE, P.C. PATIENT REGISTRATION FORM

FILL OUT FORM COMPLETELY

<b>I. PATIENT INFORMATION</b>					
NAME (Last, First, Middle Initial)	BIRTHDATE	AGE	SEX M F	SOCIAL SECURITY NO.	MARITAL STATUS S M W D
ADDRESS	CITY	STATE	ZIP	CELL PHONE ( )	
				HOME PHONE ( )	
EMPLOYER (PATIENT OR PARENT)		WORK PHONE ( )		REFERRING/PRIVATE PHYSICIAN	
RELATIVE OR FRIEND TO NOTIFY IN CASE OF EMERGENCY ( <u>NOT LIVING AT PATIENT'S RESIDENCE</u> )			RELATIONSHIP TO PATIENT		PHONE ( )
<b>INSURANCE INFORMATION</b>					
<b>INSURANCE SUBSCRIBER NAME</b>		<b>BIRTHDATE</b>	<b>RELATIONSHIP TO PATIENT</b>		<b>SOCIAL SECURITY NUMBER</b>
ADDRESS	CITY	STATE		ZIP	PHONE ( )
<b>EMPLOYER NAME AND ADDRESS</b>		CITY	STATE		ZIP PHONE ( )
NAME OF INSURANCE					
<b>2. DO YOU HAVE ADDITIONAL INSURANCE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>If yes, complete the following</b>					
NAME OF INSURANCE HOLDER		RELATIONSHIP TO PATIENT	BIRTHDATE	SOCIAL SECURITY NUMBER	
ADDRESS	CITY	STATE		ZIP	PHONE ( )
EMPLOYER NAME AND ADDRESS		CITY	STATE		ZIP PHONE ( )
NAME OF INSURANCE					
<b>How did you learn about this facility?</b>					
<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Direct Mail		<input type="checkbox"/> Drive By	
<input type="checkbox"/> Employed with Mercy Organization		<input type="checkbox"/> Advertisement		<input type="checkbox"/> Doctor Referred _____	
<input type="checkbox"/> Ask-a-Nurse		<input type="checkbox"/> HMO		<input type="checkbox"/> Employer _____	
				<input type="checkbox"/> Family _____	
				<input type="checkbox"/> Friend _____	
				<input type="checkbox"/> Other _____	
<b>AUTHORIZATION FOR TREATMENT AND BILLING:</b> I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physicians. I hereby recognize that the practice of medicine and surgery is not an exact science and I acknowledge that no one has made any representation, guarantee, or warranty to me regarding the results to be achieved by any treatments or examinations that I (or the patient) will receive as a result of services. I authorize release of my patient records, including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; psychological services records, if any; social services records, if any, including communications made by me to a social worker or psychologist; records of Human Immunodeficiency Virus (HIV) testing including results, if any; records of treatment for Acquired Immune Deficiency Syndrome (AIDS), if any, and records of a communicable disease, if any; to my insurance company(s) for the purpose of payment of bill and to my health care provider for continuity of care. <b>I authorize and request my insurance company to pay directly to the provider the amount due for medical care. IN ADDITION, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY AMOUNTS THAT ARE NOT COVERED, AUTHORIZED OR PAID BY MY INSURANCE COMPANY. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.</b> I understand that if any employee, physician, or agent of CIM sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound exposure to my blood or other bodily fluids, I may be tested for Human Immunodeficiency Virus (HIV) which causes Acquired Immune Deficiency Syndrome (AIDS). <b>I HEREBY CERTIFY THAT THE CONTENTS OF THIS FORM ARE UNDERSTOOD BY ME. PARAGRAPHS OR LINES THAT I CHOOSE NOT TO PERTAIN TO ME, IF ANY, WERE STRICKEN BEFORE I SIGNED:</b>					
Signature _____		Date (valid for one year) _____		Witnessing Signature Only _____	

Your insurance will be billed for those services that are covered benefits.

*Thank You*

**PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED**