StatCare Clinic Registration

PATIENT INFORMATION

Name:____ Date of Birth:_____/______/_____ Age: ____ Sex_____
Last First MI

SSN:___________________________________ Best Phone: (_________)__________________________

Your Address:____Alternate phone :(_______)_____________________

City:____ State:_____________ Zip Code: _____________________

Employer:___________________________________ Work Phone :(_________)______________________

Primary MD: ________________________________Clinic/city:____

Occupation:___________________________________ Marital Status: ________________________________

Spouse's Name: _____________________________________ BestPhone#_________________________________

Privacy statement: The privacy of your medical record is protected by state and federal law; no personal data may be released to another party without your written consent, unless required for law enforcement purposes.

INSURANCE INFORMATION

PRIMARY: ___________________________________

Subscriber Name: _____________________________________ Policy #:________________________ Group #________

Subscriber DOB: _________________________ Subscriber SSN: ____

Relation to Patient:___________________________________Subscriber Employer: ______________________________

SECONDARY INSURANCE: ________________________________

Subscriber Name: _____________________________________ Policy #:________________________ Group #________

Subscriber DOB: _________________________ Subscriber SSN: ____

Relation to Patient:___________________________________Subscriber Employer: ______________________________

EMERGENCY CONTACT INFORMATION

Name: ____ Relation to Patient: __________________

Best Phone #: (_______)_________________________ Alternate Phone : (_______)_________________________________

I authorize my insurance benefits to be paid directly to the physician, and I acknowledge I am financially responsible for all charges not covered by my insurance, including any copays or deductibles, and goods or services provided by StatCare but not covered by my insurance. I hereby consent to the release of my medical record to my insurance company and/or Medicare and its authorized subcontractors, including any and all psychiatric, alcohol or drug abuse records, HIV or other STD results as needed to permit StatCare to file medical claims on my behalf.

I agree to promptly pay for the services rendered for me or the patient named above. If I fail to meet my financial commitment to StatCare and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees, and a $25 fee for every NSF check. I further agree to pay for any missed appointments for which I did not provide at least 4 hours notice, except in case of genuine emergency or incapacity due to illness.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:

Signed____ Date:____