Patient Registration

[Please Print]

GP PC
GREATWOOD
PRIMARY AND PREVENTIVE
CARE

PATIENT INFORMATION

Name: _____ Date of Birth: _____ SSN#: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ married ☐ single ☐ separated ☐ divorced ☐ widowed E-mail Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home ☎ #: _____ Mobile ☎ #: _____ Work ☎ #: _____

Employer: _____ Employment Status: ☐ employed ☐ unemployed ☐ retired ☐ student

Address: _____ City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT (Not Living With You)

Name: _____ Home ☎ #: _____ Work/Mobile ☎ #: _____

Relationship to patient: ☐ spouse ☐ parent ☐ legal guardian ☐ other (please specify)_____

INSURANCE INFORMATION

Insurance Company: _____

Claims Address: _____

City: _____ State: _____ Zip Code: _____

Full Name of Policy Holder: _____

Policy Holder's SSN#: _____

Policy Holder's Date of Birth: _____

ID #: _____ Group #: _____

FOR OFFICE USE ONLY

Effective Date: ____ / ____ / ____ Co-pay: $_____

Annual deductible: $_____

Deductible remaining: $_____

After deductible, insurance will pay at: _____%

Lab preference: _____

Verification date: ____ / ____ / ____ Spoke with: _____

Relationship to patient: ☐ spouse ☐ parent ☐ legal guardian ☐ other (please specify)_____

FINANCIAL RESPONSIBILITY

☐ Check here if "Self" and proceed to next section

Name: _____ Date of Birth: _____ SSN#: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip Code: _____

Home ☎ #: _____ Mobile ☎ #: _____ Work ☎ #: _____

Employer: _____ E-mail Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Relationship to patient: ☐ spouse ☐ parent ☐ legal guardian ☐ other (please specify)_____

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GREATWOOD PRIMARY AND PREVENTIVE CARE

PATIENT NAME:_____ **DATE:**_____

STATEMENT OF FINANCIAL RESPONSIBLITY

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits.

Signed: _____ Date: _____

(Patient / Legal Guardian)

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the names provided for professional services rendered.

Signed: _____ Date: _____

(Patient / Legal Guardian)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed the HIPAA Notice of Privacy Practices and had my questions answered.

Signed: _____ Date: _____

(Patient / Legal Guardian)

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process this claim or provide my care as required by law.

Signed: _____ Date: _____

(Patient / Legal Guardian)

I allow full disclosure of any of medical information to the following persons:

_____

Signed: _____ Date: _____

(Patient / Legal Guardian)