Health West, PC

Date: __________ 200__
Patient Since

PATIENT REGISTRATION FORM

Title: ______ (Dr. Mr. Mrs. Ms. Miss) First name: __________ Middle name: __________ Last name: __________

Preferred name: __________ Sex: M/F: ______ Marital Status: __________ (Single/Married/Divorced/Widowed/Separated)

Soc Sec number: __________

If Married

Birthday: __________ (MM/DD/YY) Age: ______ Spouse Name: __________

Children Name: /DOB __________

Place of Birth: __________

Referring Phys.: __________ Referring Physician Phone number: __________

ADDRESS

Address1: __________ City: : __________ State: ______ Postal code: __________

Home phone: __________ Work phone: __________

Mobile Phone : __________ Pager : __________ E-mail: __________

EXTENDED AND EMERGENCY PHONE NUMBERS

Emer contact: __________ Relationship: __________

E home phone: __________ E day phone: __________

Mobile phone: __________ Pager: __________

Emer. Comments: __________

EMPLOYMENT INFORMATION

Employer: __________ Job title: __________ Date hired: __________ Status: __________ (Full Time/Part Time/Temp.)

PRIMARY INSURANCE

Insurance Name: __________ Type: __________ Policy Holder: __________

ID#: __________ Group#: __________ Patient's Relation to Policyholder: __________

Ins. Ph. Num: __________ D.O.B.: __________ SSN: __________

Ins. Address: __________ Sex: M/F: ______

Patient's Co-Payment: $ __________

SECONDARY INSURANCE

Second Ins Name: __________ Sec Pol Holder: __________

Sec Ins ID#: __________ Sec D.O.B.: __________ Sex: M/F : ______

Sec Ins Group #: __________ Sec. SSN: __________

Sec Ins Ph Num: __________

Second Ins Address: __________ Pt Relation to Sec Pol. Holder: __________

Pharmacy Plan

Pharm Plan Name: __________

Pharm Plan ID: __________

Ph Plan Group: __________

Ph. Plan Phone: __________

Ph. Notice: __________

RESPONSIBLE PARTY

Guarantor Name: __________ Guar-r Address: __________

Patient Relation To Guarantor: __________ Guarantor SSN: __________

Guarantor DOB: __________ Guarantor Sex: ______ M/F Guar-r Employer: __________

I, the undersigned, hereby consent to and authorize the administration and performance of the treatments, the administration of any needed anesthetics; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, the use of prescribed medication; the performance of diagnostic procedures; the taking and utilization of cultures and performance of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assignees, may be considered medically necessary or advisable.

I fully understand that this consent is given in advance of any specific diagnostic or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I hereby authorize HealthWest, P.C. to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly yo HealthWest, P.C. of benefits otherwise payable to me. I hereby, authorize to release of my medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be considered as the original . Further, I acknowledge that I am indebted for past due charges and I understand that I am financially responsible for those charges also.

MEDICARE PATIENTS: I authorize HealthWest, P.C. to release medical information about me to Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to HealthWest, P.C.

I have reviewed and understand my PATIENT RIGHTS AND RESPONSIBILITIES. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient’s Signature (or responsible party) ___________________ Date _____________200 __