

PATIENT REGISTRATION

NAME _____
LAST FIRST MI

ADDRESS _____
CITY STATE ZIP

PHONE _____

EMPLOYER _____
 PHONE _____

SEX M F DOB **MARITAL STATUS**
_____ S _____ M _____ D _____ W

SS#

PRIMARY DOCTOR _____ REF BY _____

SPOUSE NAME _____
LAST FIRST MI D.O.B. _____

EMPLOYER _____
 PHONE _____

INSURANCE INFORMATION

PRIMARY INS. _____
CONTRACT # GROUP # COPAY

POLICY HOLDER _____
EMPLOYER

SECONDARY INS. _____
CONTRACT # GROUP # COPAY

POLICY HOLDER _____
EMPLOYER

MINOR PATIENT REGISTRATION (COMPLETE THIS SECTION IF THE PATIENT IS UNDER 18 YEARS OF AGE)

MOTHER'S NAME _____
LAST FIRST MI

ADDRESS _____
CITY STATE ZIP

DOB _____ SS# _____ PHONE _____

EMPLOYER NAME _____
 PHONE _____

FATHER'S NAME _____
LAST FIRST MI

ADDRESS _____
CITY STATE ZIP

DOB _____ SS# _____ PHONE _____

EMPLOYER NAME _____
 PHONE _____

EMERGENCY CONTACT

NAME _____
 PHONE _____

AUTHORIZATION FOR TREATMENT / PAYMENT

I hereby authorize Southview Medical Group (i.e. the physician and any / all staff) to provide medical treatment and hereby agree to pay any outstanding balance, whether paid for or denied by my insurance company or third party payor.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize any holder of medical information about me to release said information requested by insurance companies or any third party payor with whom I have coverage. Furthermore, I authorize any holder of medical information about me to release said medical information to a Physician or medical professional who may participate in my care.

ASSIGNMENT OF BENEFITS

I hereby authorize payment of benefits be made directly to Southview Medical Group, P.C., for services provided to me by Southview Medical Group, P.C. I understand that I am financially responsible for charges not covered by this assignment, including charges determined non-covered by my insurance carrier.

DATE _____

SIGNATURE OF PATIENT - IF MINOR, THEN SIGNATURE OF RESPONSIBLE PERSON _____

PATIENT CONTACT INFORMATION

Any physician, staff, employee or representative of Southview Medical Group, P.C. has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

_____	_____	_____
<small>Name</small>	<small>Relationship</small>	<small>Date of Birth</small>
_____	_____	_____
<small>Name</small>	<small>Relationship</small>	<small>Date of Birth</small>

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Southview Medical Group, P.C. or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

PATIENT SIGNATURE: _____ DATE: _____

DATE KEED: _____

IF YOU NEED A COPY FOR YOUR RECORDS PLEASE REQUEST A COPY FROM THE RECEPTIONIST