## EASTPOINTE INTERNISTS, P.C.

# REGISTRATION FORM

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| Today’s Date: [Date] | PCP: [PCP] |

PATIENT INFORMATION

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| --- | --- | --- | --- | --- |
| Patient’s last name: [Last Name] | First: [First Name] | Middle: [Initial] | [Choose an item] | Marital status: [Choose an item] |

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| --- | --- | --- | --- | --- | --- |
| Is this your legal name? | If not, what is your legal name? | Former name: | Birth date: | Age: | Sex: |
|  | [Legal Name] | [Former Name] | [Birthday] | [Age] |  |

Address: [Address/ P.O Box, City, ST ZIP Code]

|  |  |  |
| --- | --- | --- |
| Social Security no.: | Home phone no.: | Cell phone no.: |
| [SS#] | [Phone] | [Phone] |
| Occupation: | Employer: | Employer phone no.: |
|  |  |  |
| Race: Choose an item. | Ethnicity: Choose an item. | Preferred Language: Choose an item. |

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| --- | --- | --- |
| Chose clinic because/referred to clinic by (Please choose one option): |  | [Doctor’s name] |
|  |  | [Choose an item] |

Other family members seen here: [Other patients]INSURANCE INFORMATION(Please give your insurance card to the receptionist.)

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| --- | --- | --- | --- |
| Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: |
| [Responsible party] | [Birthday] | [Address] | [Phone] |
| Is this person a patient here? |  | Is this patient covered by insurance? |  |
| Occupation: | Employer: | Employer address: | Employer phone no.: |
| [Occupation] | [Employer] | [Address] | [Phone] |

Please indicate primary insurance: [Choose an item] | Other: [Other insurance]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: |
| [Name] | [SS#] | [Birthday] | [Group #] | [Policy #] | $[Co-pay] |

Patient’s relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

|  |  |  |  |
| --- | --- | --- | --- |
| Name of secondary insurance (if applicable): | Subscriber’s name: | Group no.: | Policy no.: |
| [Secondary Insurance] | [Name] | [Group #] | [Policy #] |

Patient’s relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]IN CASE OF EMERGENCY

|  |  |  |  |
| --- | --- | --- | --- |
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: |
| [Friend or relative name] | [Relationship] | [Phone] | [Phone] |

**Authorization to pay benefits to Provider, Release of Medical Information & Receipt of Notice of Privacy Policies & Practices**The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize EASTPOINTE INTERNISTS, P.C. or insurance company to release any information required to process my claims. If the amount due for services rendered become delinquent and the debt is referred to an attorney and/or third party for collection, shall recover from me, any and all costs and expenses incurred in the collection of any such delinquent amount. This includes legal interest on the balance due, together with any collection costs and reasonable attorney fees. I authorize you to give reasonable and proper medical care as determined by today’s standards. I acknowledge receipt of EASTPOINTE INTERNISTS, P.C.’s Notice of Privacy Policy.

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|  | Patient/Guardian signature |  | Date |  |

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