Patient Registration

Patient Name: ______________________ Patient's Social Security Number: ____________

Street Address: ______________________ City: ______________ Zip: ________

Date of Birth: ____________ Marital Status: S M W SEP D Sex: M F # of Children: ______

Telephone #: Home ______________ Work #____________ Cell #____________

Email: ____________________ Race: ____________ Ethnicity: ____________

Pharmacy Name: ____________________ Street: ______________ City: ________________

Mail Order Pharmacy: ________________

Spouse's Name: ________________ Spouse's Employer: ____________________

Emergency Contact: ______________ Tel# ____________ Relationship: ________

Referred By: ________________ Other Doctors: ____________________

Patient Employer Information

Employer Name: ______________________ Occupation: ______________________

Insurance Information

Primary Insurance: ________________________ Effective Date: __________

Subscriber Name: ________________ Relationship to patient: ________ DOB: _______

ID# ________________ Group# ________________ Tel# ________________

Secondary Insurance: ________________________ Effective Date: __________

Subscriber Name: ________________ Relationship to patient: ________ DOB: _______

ID# ________________ Group# ________________ Tel# ________________

I hereby authorize my provider to treat my symptoms and apply for benefits on my behalf for any services rendered by him or his order
I request that payments of authorized benefits from Medicare/Insurance Company be made directly to my provider
I authorize my provider to release any medical information about me to HCFA/my insurance and its agents, any information needed to determine these benefits or the benefits payable to related services
I authorize the use of this authorization for any of my insurance submissions
I understand that I am responsible for any amount not covered by my insurance company(s)
I certify the information that I have reported with regards to my insurance coverage is correct
I permit a copy of this authorization to be used in place of its original
This authorization may be retrieved by either me or my insurance company at any time in writing
I give permission for my provider to access my pharmacy benefits data electronically through RxHub. This consent will enable my provider to: determine the pharmacy benefits and drug co pays for a patient's health plan, check whether a prescribed medication is covered (in formulary) under a patient's plan, display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications, determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies, download a historic list of all medications prescribed for a patient by any provider.

Patient Signature ______________________ Date ________

Parent Signature ______________________ Date ________