Fitzpatrick, Moran, Costa and Haag-Rickert, F.A.C.O.G. *Patient Registration Form*
(Please Print)

Date: _____ / _____ / _____ **PCP**:

PATIENT INFORMATION

Name: _____ **DOB**: _____ / _____ /
Last First MI

Address: _____ **SS#:** _____ / _____ /
Number Street Apt. **Marital Status**: Married _____ Single
Divorced _____ Legally Separated
_____ Widowed
City State Zip
Domestic Partner

Home #:_____ **Cell #:**_____ **Work #:**

E-Mail Address:_____ **Employment**: Full Time

Employer:_____ Part Time _____ Retired
Unemployed _____ Student

Emergency Contact Information:

Name:_____ Relationship:_____ Home #: _____ Work #:

Relationship of Patient to Guarantor: Self ____ Spouse ____ Child _____ Other(Please Specify)

What is your primary language? _____ Are you hearing impaired?_____ visually impaired(legally blind)

Ethnicity: Please check one: **Race: Please check all that apply:**

9Hispanic, Latino or Spanish origin 9American Indian or Alaska Native 9 Native Hawaiian or other Pacific Islander

9 Not Hispanic or Latino 9 Asian 9 White or Caucasian 9 Black or African American 9 Other

GUARANTOR INFORMATION (Person Financially Responsible)

Guarantor Name:_____ **DOB**: _____ / _____ /
Last First MI

Guarantor Address: _____ **Sex**: Male _____ Female
Number Street Apt.

_____ **SS#**: _____ / _____ /
City State Zip

Guarantor Phone #:

HEALTH INSURANCE INFORMATION: (Copy All Cards, Front & Back)

Primary Insurance:_____ Effective Date:_____ /_____ /

Billing Address:

Policy No.:_____ Group No.:

Subscriber Name:_____ Relationship:

Subscriber's Date of Birth:_____ /_____ /_____ Subscriber Employer Name:

ASSIGNMENT OF BENEFITS

The Non-Medicare Patient: I authorize the release of all medical information necessary to process this claim and is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Fitzpatrick, Moran, Costa and Haag-Rickert.

The Medicare Patient: I request that payment of authorized Medicare/Medigap benefits be made on my behalf to Fitzpatrick, Moran, Costa and Haag-Rickert for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medical Services, its agents or my Medigap Insurer _____, any information needed to determine benefits or the benefits payable for related services.

I certify that the information given by me is correct. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I may be responsible for any amount not covered by insurance.

Signature: _____
patient parent or guardian

_____
witness date