

# U. M. G. Physician Clinic - Patient Registration

PCP \_\_\_\_\_

MR# \_\_\_\_\_

**Patient Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone No. \_\_\_\_\_ Evening Phone No. \_\_\_\_\_ Cell Phone No. \_\_\_\_\_

Sex  Male  Female Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  Single  Married  Divorced  Separated  Widowed

Social Security No. \_\_\_\_\_ Referred By \_\_\_\_\_

Patient' Employer \_\_\_\_\_ Phone No. \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Guarantor Information - Responsible For Payment**  Self (If self, no need to complete this section)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone No. \_\_\_\_\_ Evening Phone No. \_\_\_\_\_ Cell Phone No. \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_  Single  Married  Divorced  Separated  Widowed

Patient' Employer \_\_\_\_\_ Phone No. \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Primary Insurance**

Insurance Name \_\_\_\_\_ Copy of Insurance Card Provided Yes/No

Policy Holder Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_

**Secondary Insurance**

Insurance Name \_\_\_\_\_ Copy of Insurance Card Provided Yes/No

Policy Holder Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_

**Patient Authorization:** I request that payment of authorized Medicare or other payor benefits be made on my behalf to the physician for any services furnished me by this facility, realizing that I am responsible to pay non-covered services. I also authorize the physician to release any medical information to the Centers for Medicare and Medicaid Services and its agents or other authorized payors needed to determine benefits payable for related services. This authorization is in effect until I choose to revoke it.

**Privacy Notice:** I acknowledge that I was provided with a copy of United's Notice of Privacy Practices. Please refer to the Notice of Privacy Practices for more information regarding release of your health information and right to access your health information. I certify that I have read and fully understand the above and that I am competent to execute it or authorized to execute it on another's behalf.

Signature of Patient, Parent, or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_  
(please circle appropriate one)

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**Clinic Registration**