Maple Family Physicians, Inc. Patient Registration Form

Patient Name_____ Date of Birth_____ Date completed _____
Address _____ Home phone (____)_____
_____ Cell Phone (____)_____
May our office leave a message on your (home and/or cell) voice mail? (Yes or No)

Social Security Number _____ Sex: M F

Marital Status: Married Single Divorced Separated Widowed Child

Employer _____ Work phone (____)_____
Employer Address _____ Occupation _____
_____

Emergency Contact _____ Relationship_____ Phone (____)_____

Pharmacy name: _____ Pharmacy phone (____)_____
Pharmacy location:_____

Insurance information: **We will need a copy of all insurance cards front and back.**
Primary insurance _____ Secondary insurance _____
Policy holder name _____ Policy holder name _____
ID number _____ Group number_____
Mail claims to address_____ Co-pay _____
_____
Please list all family members covered by this insurance:
Name_____ Relationship_____ DOB_____
Name_____ Relationship_____ DOB_____
Name_____ Relationship_____ DOB_____
Name_____ Relationship_____ DOB_____

IF A MINOR, WHO IS RESPONSIBLE FOR CHILD'S MEDICAL EXPENSES?_____
****Our office will not get involved with separation/divorce disputes.****

Father's name_____ Mother's name _____
Father's SS #_____ Mother's SS # _____
Father's Date of Birth_____ Mother's Date of Birth _____
Employer's name_____ Employer's name_____
Employer's address_____ Employer's address_____
_____ _____

I authorize the above practice to disclose or receive any or all information relating to my evaluation at this office, including copies of my diagnostic test results, to or from my attending physician and/or such physicians as may be selected by my attending physician, at his or her discretion, for the purpose of obtaining further diagnosis and/or treatment which he or she believes is indicated.

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM. I am responsible for any referrals and/or authorizations required by my insurance company. I understand I am financially responsible for any balance not covered by my insurance.

I understand that the above practice is NOT responsible for collecting on an insurance claim or negotiating a settlement on disputed claim. I agree that I am responsible for any co-payments, deductibles, co-insurance amounts and fees for non-covered services.

I understand that the above practice is not in the business of extending credit, and I agree to pay the above practice at the time the bill is presented. If prompt payment is not made, the above practice may take action to collect its charges, which includes payment being charged to my credit card.

Signature_____ Date_____