Exclusive Medical Provider

PATIENT REGISTRATION

Patient Last Name _____ First Name _____ Middle Initial _____

Address _____ City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

SS# _____ Date of Birth _____ Sex _____ Marital Status _____

Employers Name _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Primary Insurance

Insurance Name _____ Policy # _____ Phone _____

Name of Insured _____ Relationship _____

SS# _____ Date of Birth _____

Employers Name _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

Secondary Insurance

Insurance Name _____ Policy # _____ Phone _____

Name of Insured _____ Relationship _____

SS# _____ Date of Birth _____

Employers Name _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

Referring Physician Name _____ Phone _____

PCP Name _____ Phone _____

Emergency Contact _____ Phone _____

Preferred Pharmacy _____ City _____ Phone _____

I hereby authorize providers of Marisol Health to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency.

Signature of Patient / Authorized Person _____ Date _____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims.

Signature of Patient / Authorized Person _____ Date _____

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PATIENT HIPAA QUESTIONNAIRE

- Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information:

  ( )_____

  Confidential messages can be left on this voicemail: YES_____ NO _____

  Confidential text message may be left at this number: YES _____ NO _____

- You are invited to log into our online Portal. Please provide an email address to register with the patient portal:

  _____

- Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

  _____

  _____

- Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

  Name _____ Phone_____

  Name _____ Phone_____

- Where you would like billing statements and/or correspondence from our office to be sent?

  _____

  _____

- Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

  YES _____ NO_____

PATIENT NAME_____ DATE _____

PATIENT/GUARDIAN SIGNATURE_____