



PATIENT REGISTRATION

Patient Name _____
Last First Middle Initial (Nickname)

Home Address _____
Street Apt. #

City State Zip

Home Phone () _____ **Cell Phone** () _____
Area Code Area Code

Emergency Contact _____ **Emergency Phone** () _____

Male () **Female** () **Body part being evaluated** _____

Marital Status: () Single () Married () Separated () Divorced () Widow/er

Birth date: ___/___/___ **Age:** _____ **Social Security #** _____

E-Mail _____

Primary Care Physician: _____ **Phone #** () _____

Referred by (Dr./Patient/Friend): _____

Referred By Attorney? _____ **Phone #** () _____

Patient's Employer/School: _____ **Phone #** () _____

BILLING INFORMATION

PRIMARY INSURANCE

SECONDARY INSURANCE

Ins. Co. Name: _____ **Ins. Co. Name:** _____

Subscriber Name: _____ **Subscriber Name:** _____

Date of Birth: _____ **Date of Birth:** _____

Policy #: _____ **Policy #:** _____

Group #: _____ **Group #:** _____

Employer: _____ **Employer:** _____

Does your insurance carrier require a referral? () Yes () No

Is this a labor and industries claim? () Yes () No

I request that payment of authorized Medicare or insurance benefits be made to my physician on my behalf for any services furnished me by any of the physicians of EOC. I authorize any holder of medical information about me to release to HCFA and its agents or to my insurance any information needed to determine these benefits. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, and I accept financial responsibility for non-covered services.

Signature

Date

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practice** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

This area for staff notes (if any):

This form will be retained in your medical record