PROMPTMED Patient Registration Form

NOTIFY THE RECEPTIONIST IMMEDIATELY IF YOU FEEL YOU HAVE A POTENTIALLY LIFE THREATENING SYMPTOM OR INJURY

Section 1. General Information –Please give a valid photo ID to receptionist.

First Name: _____ MI: ___ Last Name: _____

Gender: ___ Male ____ Female Age: _____ Date of Birth: _____

Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Emergency Contact: _____Emergency Contact Phone: _____

Primary Care Physician: _____ Employer: _____

Section 2. Reason for Visit – Note: We DO NOT treat patients involved in Motor Vehicle Accidents

Reason for Visit: _____

Date Symptoms Occurred: _____

A: Is this visit work related? _____Yes _____ No If you answered Yes to A, please go to section 5.

B. Is this visit auto accident related? ____Yes ____ No If you answered Yes to B, please see receptionist.

Section 3. Insurance Information (Primary Insurance) - Add Secondary Insurance in Section 6.
☐ Please check if you do not have insurance coverage.

Insurance Name: _____ (Please give your insurance card to receptionist)

☐ If same as information in Section 1, check this box and please go to section 4.

Insurance Card Holder: _____
First Name M.I. Last Name

Insured's Address: _____
Street Address City State Zip

Insured's Social Security Number: _____ Insured's Phone: _____

Insured's Date of Birth: _____ Insured's Employer: _____

Relationship to Patient: _____

FORM CONTINUED ON NEXT PAGE, PLEASE COMPLETE.

Section 4. Guarantor Information -This section only needs to be filled out if the patient is a minor or dependent.

The Guarantor is the adult who presents for treatment. In the case of a minor, it is the adult that accompanies the patient for treatment or who signed the Authorization to Treat Minor Form.

Guarantor: _____
First Name **M. I.** **Last Name**

Guarantor's Social Security Number: _____ **Guarantor's Date of Birth:** _____

Guarantor's Address: _____
Street Address **City** **State** **Zip**

Guarantor's Phone: _____ **Relationship to Patient:** _____

Section 5. Employer Information – Section only required for work related illness, injuries, or treatment & Drug / Alcohol testing.

Employer Name: _____ **If Injury, Date of Injury:** _____

Contact Name (Supervisor or person who authorized treatment): _____

Department: _____ **Employer Phone:** _____

Employer Address: _____
Street Address **City** **State** **Zip**

Section 6. Secondary Insurance Information
☐ **Please check if you do not have secondary insurance coverage.**

Insurance Name: _____ **(Please give your insurance card to receptionist)**

☐ **If same as information in Section 1, check this box and please go to section 4.**

Insurance Card Holder: _____
First Name **M.I.** **Last Name**

Insured's Address: _____
Street Address **City** **State** **Zip**

Insured's Social Security Number: _____ **Insured's Phone:** _____

Insured's Date of Birth: _____ **Insured's Employer:** _____

Relationship to Patient: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In order to bill your insurance carrier or employer, we must have authorization to release necessary medical information. The undersigned hereby authorizes release of information necessary to file a claim with my **group or commercial** insurance company / or employer and assign any benefits to PromptMed, which would otherwise be payable to the undersigned under the terms of the insurance policy. The undersigned understands that they are financially responsible for any balance not covered by the insurance company and hereby obligates to pay the account of the treating health care provider in accordance with the regular rates and terms of said providers. The undersigned recognizes that all treating health care providers furnishing services to the patient may send a separate statement or account from/for each such health care provider.

_____ _____
Signature (patient/guardian) Date

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made to PromptMed on my behalf, for any services furnished to me by or in PromptMed, including physician services. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits for related services. I understand I am financially responsible for any balance not covered by my insurance company.

_____ _____
Signature (patient/POA) Date