

**PATIENT REGISTRATION**

please print clearly

**INSTITUTE FOR SPECIALIZED MEDICINE**

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<b>Today's Date</b>	<b>Are you a new Patient?</b> YES      NO	<b>Who were you referred by?</b>
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**PATIENT INFORMATION**

<b>PATIENT'S NAME</b>		
<b>LAST</b>	<b>FIRST</b>	<b>M.I.</b>
<b>BILLING ADDRESS</b>		
<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
<b>PERMANENT ADDRESS (if different)</b>		
<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
<b>HOME PHONE</b> ( ) -	<b>WORK PHONE</b> ( ) -	<b>CELL PHONE</b> ( ) -
<b>E-MAIL:</b>		
<b>GENDER</b> MALE      FEMALE	<b>BIRTHDAY</b>	<b>PATIENT SOCIAL SECURITY #</b>
<b>MARITAL STATUS</b> SINGLE      MARRIED      REGISTERED DOMESTIC PARTNER		
<b>PATIENTS OCCUPATION AND EMPLOYER</b>		
<b>RESPONSIBLE PARTY NAME (if not the patient)</b>		
<b>LAST</b>	<b>FIRST</b>	<b>M.I.</b>
<b>RESPONSIBLE PARTY ADDRESS</b>		
<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
<b>HOME PHONE</b> ( ) -	<b>WORK PHONE</b> ( ) -	<b>CELL PHONE</b> ( ) -
<b>DO YOU HAVE AN "ADVANCE MEDICAL DIRECTIVE"?</b> YES      NO	<b>MAY WE KEEP A COPY ON FILE?</b> YES      NO	

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**INSURANCE INFORMATION**

**(PLEASE PROVIDE COPIES OF ALL I.D. CARDS – FRONT AND BACK, IF APPLICABLE)**

*Please be aware that it is common for insurance companies to subcontract certain benefits to another company. In these instances, we may not bill your insurance company; we may be required to bill your medical group or third party payer. It is your responsibility to know if this is true. If you are not sure, the office staff may be able to assist you.*

**PLEASE CHECK HERE IF YOU HAVE NO INSURANCE AND YOU WILL BE SOLELY RESPONSIBLE FOR PAYMENT**

<b>PRIMARY INSURANCE COMPANY</b>		<b>SECONDARY INSURANCE COMPANY</b>	
<b>INSURANCE PHONE #</b> ( ) -	<b>EFFECTIVE DATE</b>	<b>INSURANCE PHONE #</b> ( ) -	<b>EFFECTIVE DATE</b>
<b>CLAIMS ADDRESS</b>		<b>CLAIMS ADDRESS</b>	
<b>SUBSCRIBER NAME</b>	<b>DATE OF BIRTH</b>	<b>SUBSCRIBER NAME</b>	<b>DATE OF BIRTH</b>
<b>SUBSCRIBER ID #</b>	<b>GROUP #</b>	<b>SUBSCRIBER ID #</b>	<b>GROUP #</b>
<b>RELATIONSHIP OF SUBSCRIBER TO PATIENT</b> SELF SPOUSE CHILD OTHER _____		<b>RELATIONSHIP OF SUBSCRIBER TO PATIENT</b> SELF SPOUSE CHILD OTHER _____	

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**PRIMARY CARE PHYSICIAN**

PRIMARY CARE PHYSICIAN NAME	PHYSICIAN PHONE ( ) -	
PRIMARY CARE PHYSICIAN ADDRESS (IF KNOWN)		
CITY	STATE	ZIP
e-mail:		
MAY WE CONTACT YOUR PHYSICIAN SO THAT HE/SHE MAY BE FULLY INFORMED AND MAY WE COORDINATE TREATMENT IF NECESSARY?		
YES		NO

**EMERGENCY CONTACT INFORMATION**

EMERGENCY CONTACT PERSON		RELATIONSHIP TO PATIENT
HOME PHONE ( ) -	WORK PHONE ( ) -	CELL PHONE ( ) -

**AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS AND CERTIFICATION OF ACCURATE INFORMATION**

I hereby authorize the Institute for Specialized Medicine to release information which is normally required in the course of my treatment for the sole purpose of processing any insurance claim(s) submitted.

I hereby authorize my insurance company to send payment directly to the Institute of Specialized Medicine for any insurance benefits for services rendered. I understand that I am financially responsible for any unmet deductible, co-pays and for any charges of services not covered by my insurance, unless specifically prohibited by my insurance plan.

I have reviewed the preceding information and I certify that this information is correct. I further understand that I am responsible for any financial loss due to inaccurate or incomplete information provided by me.

PRINTED NAME: \_\_\_\_\_

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_  
(patient or responsible party, if patient is a minor)