PATIENT REGISTRATION FORM

*** PLEASE PROVIDE YOUR INSURANCE CARD(S) TO THE REGISTRAR ***

Patient Name :_____

Address: _____Apt#_____City:_____ State____
Zip_____

Home Phone: (_____)_____ Bus. Phone: (____)_____ Cell Phone: (____)_____

Social Security # _____/_____/_____

Sex: Male Female Date Of Birth: _____/_____/_____

Marital Status (circle one): Married Single Widowed Divorced Separated

Employment Status (circle one): Full-time Part-time Retired Self Employed Unemployed Student

Emergency Contact Name :_____ Phone: (_____)_____

Address: _____ Apt#_____ Alt. Phone: (_____)_____

City:_____ State_____ Zip_____ Relationship _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name _____ Policy # _____

Primary Care Physician: _____ Policy Holder Name (if not you)_____
D.O.B._____

OB/GYN (if applicable) SSN:

SECONDARY INSURANCE INFORMATION

Insurance Company Name _____ Policy # _____

RESPONSIBLE PARTY INFORMATION (if different than above)

Name :_____ Home Phone: (_____)_____

Address: _____ Apt#_____ Bus. Phone:
(_____)_____

City:_____ State____ Zip_____ Social Security # _____

Employer:_____ Employer
Address:_____

FOR SELF PAY PATIENTS

If you have difficulty paying the full amount of your bill, you may apply for a sliding fee discount. Please request a copy of the application from the Registrar. You may also request to speak to a patient services coordinator should you have personal or insurance issues.

MEDICAID PATIENTS ARE REQUIRED TO PAY A $3 COPAY.

THIS DOES NOT APPLY FOR OBSTETRICS OR FOR PEDIATRICS

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to be sent directly to the CMADC Inc. or its individual providers for services rendered.

FINANCIAL AGREEMENT: I understand and agree that I am ultimately responsible for payment of my account for any professional services rendered. Should my insurance company claim (whether private insurance, Medicare &/or Medicaid) be denied for lack of eligibility, termination of coverage or non-covered services, I will be held responsible and will make payment for any balance due. I am also responsible for payment for any unanticipated procedures, lab work and/or tests that are administered and not covered under my insurance policy. If I applied for a sliding fee scale, and my application is denied, or if there is a balance due for that visit, I am responsible to pay that balance.

PATIENT BILL OF RIGHTS/ACCESS TO MEDICAL RECORDS: I have been informed that I am entitled to view my medical records.

AUTHORIZATION OF TREATMENT: I hereby give permission to the staff of CMADC, Inc. to provide medical treatment for the above named patient and to release the respective medical information for reimbursement purposes.

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby give permission to the staff of CMADC, Inc. to request any medical information including but not limited to labs, paps, mammograms and progress notes from my primary care physician or from any other medical facility.

APPOINTMENT CONFIRMATIONS: I consent to having CMADC, Inc. representatives leave information on my answering machine for services such as reminder for treatment, appointments, confirmation of information, or returning your phone call.

_____

Signature of Patient/Guardian Print Date

REQUIRED PAYMENT MUST BE MADE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE

Name_____

PATIENT REGISTRATION FORM (continued)

Please circle the most applicable answer for each question below:

Ethnicity: Black/ African American | Asian (including Indian or Pakistani) | Hispanic or Latino |

Multi-racial Native American | Alaskan White/Caucasian | Native Hawaiian Pacific Islander |

Other: _____ | Unreported/Refused to State Latino / Hispanic Descent (Y/N) _____

Languages spoken at home please circle all that apply:

English | Russian | Polish | Yiddish | Hebrew | Spanish | Creole | Other: _____

Are you a veteran? (Y/N)_____

Interpretation Services Needed? Yes/ No

English | Russian | Polish | Yiddish | Hebrew | Spanish | Creole | Other: _____

Type of Household (please circle all that apply):

Single +18 | Single +18 w/child | Married | Married w/children | Foster Child Living alone under 18 |

Child Head of Household under 18 | Widow/Widower | w/Significant Other | w/Significant Other + child

Source(s) of Income (please circle all that apply):

Employment | AFDC | SSD/SSI SSA | Unemployment | Workmans Comp | Pension/Retirement Benefit |

VA Benefits | Alimony/Child Support | None | Other_____

Referred By: Friend | Relative | Other Provider | Outside Agency | Self

Current Living Arrangements If Homeless (circle one): Shelter Transitional w/Family w/Unrelated People Streets Migrant Seasonal Doubling Up
Other_____

Reasons for Homelessness (circle one): Eviction | Unemployment | Disaster displacement | Abuse |

Mental Impairment | Substance Abuse | Physical Impairment | Other_____

Is the patient enrolled in the WIC program? Yes | No

Household Income $:_____ /per (circle one): Week | Biweekly | Year

Family Size:_____

Approximate Income Level (circle one): $9,000 | $15,000 | $20,000 | $25,000 | $30,000 | $35,000 | $40,000 $45,000 | $50,000 | $60,000 | $60,000+