PATIENT REGISTRATION FORM

PLEASE COMPLETE THE ENTIRE FORM – BOTH SIDES

PATIENT INFORMATION

Last Name:______________________________ First Name:__________________ M.I.____

Social Security #:______________________ Date of Birth: _____________ Gender: M F (circle one)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Race: ☐ Decline to specify ☐ Asian ☐ African American ☐ American Indian or Alaska Native ☐ Caucasian
☐ Native Hawaiian or Other Pacific Islander ☐ Other:____________________

Ethnicity: ☐ Decline to specify ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino ☐ Other:__________

Mailing Address:____

City:______________________________ State:______________ Zip:____________

Email Address:____

Home Phone:________________ Cell Phone:________________ Work:________________

Driver's License Number:____________________ Spouse's Name:____________________

Referring Physician:____________________ Primary Care Physician:____________________

City:____________________ City:____________________

PERSON RESPONSIBLE FOR THE BILL - Only applicable if other than patient:

Last Name:______________________________ First Name:__________________ M.I.____

Relationship to patient:____________________ Home Phone:____________________

Mailing Address:____

City:______________________________ State:______________ Zip:____________

INSURANCE INFORMATION

Primary Insurance Company: ☐ Medicare ☐ Medicaid ☐ Other:______________________

Policy #____________________ Group #________________ Effective Date:__________

Policy Holder Name: ____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Other:______________________

Policy Holder's Date of Birth: _____________ Gender: M F Social Security #__________________

Employer:______________________________ Phone:____________________

Secondary Insurance Company: ☐ Medicaid ☐ Other:______________________

Policy #____________________ Group #________________ Effective Date:__________

Policy Holder Name: ____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Other:______________________

Policy Holder's Date of Birth: _____________ Gender: M F Social Security #__________________

Employer:______________________________ Phone:____________________

CONTINUED ON OTHER SIDE:

ADDITIONAL PATIENT INFORMATION:

Employment: ☐ Active Duty ☐ Full Time ☐ Not Employed ☐ Part Time ☐ Retired ☐ Self Employed
☐ Student – full time ☐ Student – part time

Name of Employer:______________________________ Occupation:______________________________

Preferred Language: ☐ English ☐ Spanish ☐ Other:______________________________

Emergency Contact:______________________________ Relationship:______________________________

Emergency Contact Home Phone:______________________________ Cell Phone:______________________________

Local Pharmacy Name:______________________________ City:______________________________

Pharmacy Phone______________________________

How did you hear about our doctor? ☐ TV ☐ Newspaper ☐ Web search ☐ Radio ☐ Doctor:________________
☐ Friend/Family – Name:______________________________

IMPORTANT INFORMATION

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by Leo W. Mack, Jr., M.D., P.A. physicians, employees and such associates, assistance, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations and treatment. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this consent to treatment will be valid and remain in effect as long as I receive care from this practice, unless revoked by me in writing.

RELEASE OF INFORMATION: I understand my signature authorizes release of confidential medical information necessary to pay the claim to Medicare or other health insurer. I understand that I may revoke this authorization at any time, by providing written notice to Leo W. Mack, Jr., M.D., P.A., except to the extent that action has been taken in reliance on it.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign my right, title and interest in all insurance, Medicare/Medicaid, or other third party payor benefits for medical or health care services payable to me, payable to the providers of Leo W. Mack, Jr., M.D., P.A. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third party payor, up to the total amount of my medical and health care charges, to the providers of Leo W. Mack, Jr., M.D., P.A. I certify that the information I have provided in connection with any application for payment by third party payors, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by or which exceed the estimated amount to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third party payor and agree to make payment as requested by Leo W. Mack, Jr., M.D., P.A.

REFRACTION: I understand that the refraction (measurement of eyes for glasses / contacts) is a NON-COVERED service. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refraction fee.

NOTICE OF PRIVACY PRACTICES: I acknowledge that a copy will be made available upon my request.

______________________________ ______________________________
Signature of patient (or responsible party) Date