



PATIENT REGISTRATION

| | | |
|------------------------------|--------------------|-------------------|
| REG. DATE ____ / ____ / ____ | CHART LOC. # _____ | MED. REC. # _____ |
| PCP _____ | FIN CLASS _____ | CO-PAY _____ |

PLEASE PRINT *DO NOT PRINT IN THE AREA ABOVE

PATIENT INFORMATION

| | | | |
|---|----------------------------|--|--|
| FIRST NAME: | MIDDLE INITIAL: | LAST NAME: | PRIMARY LANGUAGE: |
| DATE OF BIRTH: | SOCIAL SECURITY: | | SEX: |
| STREET ADDRESS: | APT. # | CITY: | STATE: |
| HOME PHONE #: | CELL #: | | ZIP CODE: |
| EMPLOYER / SCHOOL: | ADDRESS: | | OCCUPATION: |
| FULL TIME ____ PART TIME ____ RETIRED ____ STUDENT ____ | RELATIONSHIP TO GUARANTOR: | | SELF ____ SPOUSE ____ PARENT ____ OTHER ____ |
| MARITAL STATUS: | EMPLOYED: | SMOKER <input type="checkbox"/> YES <input type="checkbox"/> NO DIABETIC <input type="checkbox"/> YES <input type="checkbox"/> NO ASTHMATIC <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| SINGLE ____ MARRIED ____ DIVORCED ____ WIDOWED ____ | WORK PHONE #: | | |

GUARANTOR / RESPONSIBLE PARTY INFORMATION

| | | |
|---|--|-----------------|
| FIRST NAME: | LAST NAME: | MIDDLE INITIAL: |
| DATE OF BIRTH: | SOCIAL SECURITY: | |
| STREET ADDRESS: | APT. # | CITY: |
| HOME PHONE #: | STATE: | |
| EMPLOYER / SCHOOL: | ADDRESS: | |
| EMPLOYED: | RELATIONSHIP TO GUARANTOR: | |
| FULL TIME ____ PART TIME ____ RETIRED ____ STUDENT ____ | SELF ____ SPOUSE ____ PARENT ____ OTHER ____ | |
| | WORK PHONE #: | |

EMERGENCY CONTACT INFORMATION

| | | | |
|------------------|--------------------------|-------------|---------------------|
| PRIMARY CONTACT: | RELATIONSHIP TO PATIENT: | HOME PHONE: | WORK / OTHER PHONE: |
|------------------|--------------------------|-------------|---------------------|

PRIMARY INSURANCE INFORMATION

| | | |
|---|--------------------------|-------------------------------|
| INSURANCE COMPANY: | GROUP NAME OR NUMBER: | INSURANCE / MEMBER ID NUMBER: |
| RELATIONSHIP TO POLICY HOLDER: | POLICY HOLDER LAST NAME: | FIRST NAME: INITIAL: |
| SELF ____ SPOUSE ____ CHILD ____ OTHER ____ | SEX: DATE OF BIRTH: | PHONE: |
| ADDRESS: | CITY: | STATE: ZIP CODE: |

SECONDARY INSURANCE INFORMATION

| | | |
|---|--------------------------|-------------------------------|
| INSURANCE COMPANY: | GROUP NAME OR NUMBER: | INSURANCE / MEMBER ID NUMBER: |
| RELATIONSHIP TO POLICY HOLDER: | POLICY HOLDER LAST NAME: | FIRST NAME: INITIAL: |
| SELF ____ SPOUSE ____ CHILD ____ OTHER ____ | SEX: DATE OF BIRTH: | PHONE: |
| ADDRESS: | CITY: | STATE: ZIP CODE: |

HOW DID YOU HEAR ABOUT US?

WOULD YOU LIKE TO COMMUNICATE WITH YOUR PHYSICIAN BY EMAIL? YES NO

EMAIL ADDRESS: _____

**YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS
ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT FOR SERVICES RENDERED**

All Patients

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and / or surgical benefits, including major medical benefits to which I am entitled, to Pioneer Medical Groups. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I request this authorization also apply to all other insurance.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient / Responsible Party: _____ Date: _____

Witness: _____

The Medicare Patient. (Lifetime Authorization)

I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other pertinent information or documentation needed for this of a related Medicare claim. I authorize the physician organization to submit a claim to Medicare on my behalf. I request the payment for services provided be made directly to the physician organization.

I request this authorization also apply to all other insurance.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient / Responsible Party: _____ Date: _____

Witness: _____

HIPAA DISCLOSURE NOTIFICATION AND AGREEMENT

Pioneer Medical Group may use or disclose your health care information without authorization for the purpose of coordinating a treatment plan, payment for services, and to evaluate the quality of care that you receive.

Pioneer Medical Group may also disclose your health care information for the purpose of research, public health, auditing, law enforcement, and emergencies. We are required by law to provide medical information that is court ordered and or requested by law enforcement officials.

We may contact you to provide appointment reminders, information about treatment alternatives, and or other health related benefits and services that are applicable to your medical care.

Any other use and or disclosures not listed above will require your written authorization before disclosing protected health care information.

You have the right to revoke such a request in writing and we will honor your request, except under uncontrollable circumstances in which we acted on your initial authorizations.

We reserve the right to change our policies at any time. Any significant changes to our policy will be posted immediately in the patient waiting areas and in each examination room. You may also request a copy of our current privacy practices at any time.

I have read and understand the following conditions and I am authorizing Pioneer Medical Group to disclose my Protected Health Care Information as stated in this agreement.

Patient Signature: _____ Date _____

Guardian's Signature: _____ Date _____