

For individual patients, complete patient, responsible party and contact sections below.
 For families, complete all sections below.

Date Completed: _____

MR# _____

P A T I E N T	Legal Name: Last First Initial			Social Security #	
	Address			Phone #	
	City	State	Zip	Marital Status	How did you hear about us?
	Work Phone	Extension	Cell Phone	Drivers License #	Occupation
	Employer or School			E-Mail Address	
	Employer or School Address		Date of Birth		Physician
	Spoken Language <input type="checkbox"/> English Speaking <input type="checkbox"/> Non English Other <input type="checkbox"/> Spanish Speaking <input type="checkbox"/> Vietnamese Speaking			Race: <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> African <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Unknown	
R E S P O N S I B L E P A R T Y	Legal Name: Last First Initial * Same as Patient			Social Security #	
	Address			Phone #	
	City	State	Zip	Marital Status	How did you hear about us?
	Work Phone	Extension	Cell Phone	Drivers License #	Occupation
	Employer or School			Employer #	
	Employer or School Address		Date of Birth		Physician
S P O U S E	Legal Name: Last First Initial			Social Security #	
	Address			Phone #	
	City	State	Zip	Marital Status	How did you hear about us?
	Work Phone	Extension	Cell Phone	Drivers License #	Occupation
	Employer or School			Employer #	
	Employer or School Address		Date of Birth		Physician
C O N T A C T	Emergency Contact		Work Phone	Phone #	Cell Phone#
	Next of Kin * Same			Phone #	Cell Phone#
	Relationship			Phone #	Cell Phone#

Page 2 Registration Form (continued)

*(All areas of this form should be completed for individuals or families.)

Patient or Head of Household Name:			
PRIMARY INSURANCE	Subscriber name	Date of Birth	Phone #
	Insurance name	Contract #	Group #
	Insurance address	City	State Zip Code
	Employer	Insurance Co-pay	Effective date
SECONDARY INSURANCE	Subscriber name	Date of Birth	Phone #
	Insurance name	Contract #	Group #
	Insurance address	City	State Zip Code
	Employer	Insurance Co-pay	Effective date
ADDITIONAL INSURANCE	Subscriber name	Date of Birth	Phone #
	Insurance name	Contract #	Group #
	Insurance address	City	State Zip Code
	Employer	Insurance Co-pay	Effective date

Authorization to pay benefits to the physician and release of information:

I authorize Advantage Health Physicians to bill my Insurance Co., releasing any medical information required regarding exams and treatment. I recognize and accept responsibility for services rendered regardless of insurance coverage. I understand that my payment is expected at the time of service. This includes but is not limited to coinsurance, co-payment, deductible and non-covered services.

Policy Holder Signatures _____

Date- _____

Spouse Signatures _____

Date _____

Medicare Authorization:

I hereby authorize payment of Medicare benefits to be made directly to Advantage Health Physicians for any services rendered to me by providers employed by that corporation. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed for the purpose of determining these benefits. I understand that this authorization is in effect until revoked, in writing, by me.

Beneficiary Signature _____

Date _____

Beneficiary Signature _____

Date _____

Saint Mary's Health Care and Advantage Health, as partners in your health care needs, may share certain computerized information, including patient name, address, insurance and employer. Please be assured we will manage your information appropriately and confidentially.

