SSD MEDICAL GROUP

Patient Registration Form

Patient Information:

Patient Name: ______________________________________ Date of Birth: __________ Sex: M ___ F ___
(Last) (First) (MI)

Home Address: ____________________________ City: ____________ State: ______ Zip Code: __________

Social Security No: ________________ Home Phone: ________________ Cell Phone: ________________

Ethnicity: Hispanic or Non-Hisp. Race: ________ Preferred Language: __________ Translator Needed? ____

E-mail Address: ______________________________ Would you like to access your chart electronically? ____

Employer Information:

Employer Name: ____ Work Phone: ________________

Employer Address: __________________________ City: ____________ State: ____ Zip Code: __________

Insurance Information:

Primary Ins. Company: ____________________________ Subscriber Name: ____________________

If subscriber different from patient, Relationship to Patient: ________________ Date of Birth: ____________

Secondary Ins. Company: Subscriber Name:

If subscriber different from patient, Relationship to Patient: ________________ Date of Birth: ____________

In Case of Emergency:

Contact Name: ______________________ Relationship to Patient: ____________ Phone: ________________

Contact Name: Relationship to Patient: Phone:

Pharmacy:

Name: Location: Phone:

How did you hear about us?:

Friend/Family Insurance Internet Newspaper Flyer/Mailer Other

Authorization and Assignment:

I hereby authorize my insurance carrier, attorney or any third party payer to pay directly to SSD Medical Group or its agent all charges submitted for services incurred by me. I understand I will be responsible for any and all charges not paid by my insurance company.
I authorize SSD Medical Group to release information concerning my medical condition to my insurance company, employer, hospital, physician or attorney for the purpose of processing a claim. I assign payment directly to SSD Medical Group which may be due from the Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or part the medical services which I have received. The authorization and assignment shall be valid until I notify SSD Medical Group in writing of the cancellation. A photocopy of this authorization shall be valid as the original copy.

Signature: ____ Date: ________________