SSMHealth

Patient Registration Information

Fill out this section only if "Bill to Name" and/or address is different than the patient. The "Bill To" person needs to be an adult, parent or guardian.

Bill To Name: _____ Relationship: _____
(First) (Middle) (Last)

Address: _____
(Street and P.O. Box) (City) (State) (Zip)

Home Ph: ( )_____ Social Security Number: _____Birth Date_____/_____/_____

Patient Information

Patient Name: _____
(First) (Middle) (Last)

Address: _____
(Street and P.O. Box) (City) (State) (Zip)

Home Ph: ( ) _____ Cell Ph: ( )_____ email: _____

Other Ph. Contact: ( )_____ Name of Contact:_____

Birth Date: _____/_____/_____ Sex Male Female Marital Status S M D W

Social Security Number: _____ Name of referring Physician (if applicable)_____

Patient's Employer: _____Address: _____
(Street) (City) (State) (Zip)

Work Ph: ( )_____Ext: _____

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Insurance Information

Does the patient have health insurance? Yes No If yes, please let us make a copy of your card so we may bill your insurance for your visit. If no card is provided, you're responsible for payment at the time of service.

Card Holder Name: _____ Social Security Number: _____
(First) (Middle) (Last)

Address: _____
(Street or P.O. Box) (City) (State) (Zip)

Home Phone Number: (_____)_____ Date of Birth: _____/_____/_____ Sex: Male Female

Insurance Card Holder Employer Information: Name of Employer: _____

Address: _____Work ph. number: ( ) _____Ext:_____
(City) (State) (Zip)

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare/Medicaid assignment of benefits apply. I understand that I am financially responsible for all charges not covered by this authorization.

I, _____, give permission for Dr. _____ and/or staff to discuss all labs and/or medical problems with_____, relationship_____.

Signature: _____ **Date:** _____ **Relationship:** _____
Patient or Guardian If other than Patient

Signature: _____ **Date:** _____ **Relationship:** _____
Patient or Guardian If other than Patient

Signature: _____ **Date:** _____ **Relationship:** _____
Patient or Guardian If other than Patient

Signature: _____ **Date:** _____ **Relationship:** _____
Patient or Guardian If other than Patient

See Back of Form for Additional Information