MEDCARE MEDICAL CENTER

# PATIENT REGISTRATION *(Please Print)*

## Patient Information

Name _____ Age _____

Address _____

City _____ State _____ Zip _____

Home Phone ( _____ ) _____ Work Phone ( _____ ) _____

Date of Birth _____ ❑ Male ❑ Female

Marital Status ❑ M ❑ S ❑ D ❑ W Social Security No. _____

Name of Employer _____ Occupation _____

How were you referred to our office? ❑ Location ❑ Yellow Pages

❑ Friend/Relative ❑ Internet ❑ Employer

❑ Referred by Dr. _____

## Guarantor Information

Responsible Party (if a minor) _____

Address _____

City _____ State _____ Zip _____

Home Phone ( _____ ) _____ Social Security No. _____

Relationship to Patient _____

## Insurance Information

Name of Insurance Company _____

Subscribers Name _____ Date of Birth _____

Subscriber's Relationship to Patient ❑ Self ❑ Spouse ❑ Parent Other _____

ID No. _____ Group No. _____

Claims Address _____

City _____ State _____ Zip _____

Do you have secondary insurance coverage? ❑ Yes ❑ No

If so, what is the name of the insurance company? _____

## Worker's Compensation Information

Industrial Insurance Carrier _____

Address _____

City _____ State _____ Zip _____

Employer at time of injury _____

Employer's Phone No. ( _____ ) _____ Supervisor _____

Date of Injury _____ Area Injured _____

Has this injury been reported to your employer? ❑ Yes ❑ No

## Authorization

I, the undersigned, consent to medical care rendered by MedCare Medical Center. I hereby authorize release of any information necessary to process this claim and authorize benefits to be paid directly to MedCare.

Health Insurance is becoming very complex with varying and changing insurance companies and plans. Ultimately, it is the patient's responsibility to pay for services provided by MedCare.

Signature _____ Date _____