PATIENT REGISTRATION (*Please Print*)

Patient Information

Name ______________________________ Age __________

Address ______________________________

City ______________________________ State ______________ Zip ______________

Home Phone (_______)______________________ Work Phone (_______)______________________

Email ______________________________ Date of Birth ____/______/____ Sex: ☐ Male ☐ Female

Social Security Number ______________________________ Marital Status: ☐ M ☐ S ☐ W ☐ D

Referral Information

How did you find Med Care Medical Center?

☐ Employer ☐ Location ☐ Internet Search (Google, etc.) ☐ Other ______________

☐ Relative ☐ Friend ☐ Yellow Pages ☐ Dr. ______________

Guarantor Information

Responsible Party (if a minor) ______________________________

Address ______________________________ City ______________________________

State ______________ Zip __________ Home Phone (______)______________________

Relationship to Patient ______________________ Social Security Number ______________________

Insurance Information

Name of Insurance Company ______________________________

Subscribers Name ______________________________ Date of Birth ____/______/____

Subscribers Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other ______________

ID Number ______________________ Group Number ______________________

Claims Address ______________________________

City ______________________________ State ______________ Zip ______________

Home Phone (_______)______________________ Work Phone (_______)______________________

I have secondary insurance coverage ☐ No ☐ Yes If yes, Insurance Company ______________

Worker's Compensation Information

Industrial Insurance Carrier ______________________________

Address ______________________________

City ______________________________ State ______________ Zip ______________

Employer at time of injury ______________________________ Date of Injury ______________

Authorization

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

Health insurance is becoming very complex with varying and changing insurance companies and plans. Ultimately, it is the patient' responsibility to pay for services provided by Med Care Medical Center.

Signature ______________________________ Date ______________________