ERTEL MEDICINE & PEDIATRICS

Patient Registration Questionnaire

PATIENT INFORMATION

Name ______________________________

Address ______________________________

Home Phone ______________________________

Work Phone ______________________________

City ______________ State __________ Zip __________

Sex ❑ M ❑ F Birth Date ______________

Employer Name ______________________________

Employer Address ______________________________

Social Security Number ______________________________

Marital Status ______________________________

GENERAL INFORMATION

Who Is Financially Responsible For Payment?

____

Primary Care Physician? ______________________________

Whom May We Thank For Referring You?

____

IN CASE OF EMERGENCY NOTIFY

Name ______________________________

Relationship ______________________________

Phone ______________________________

Address ______________________________

City ______________ State __________ Zip __________

Home Phone ______________________________

Daytime Phone ______________________________

PRIMARY INSURANCE INFORMATION

Please Give Card(s) To Receptionist To Copy

Name of Insurance ______________________________

Mail Claims To ______________________________

______________________ Phone ______________

Effective Date ______________________________

Plan Code ______________________________

Subscriber ID# ______________ Group # ______________

CARDHOLDER INFO

Name of Cardholder ______________________________

Date of Birth ______________________________

Social Security Number ______________________________

Address ______________________________

City ______________ State __________ Zip __________

Insurance ID# ______________________________

What is The Patient's Relationship
To The Cardholder? ______________________________

SECONDARY INSURANCE INFORMATION

Name of Insurance ______________________________

Name of Cardholder ______________________________

Date of Birth ______________________________

Social Security Number ______________________________

Address ______________________________

City ______________ State __________ Zip __________

Insurance ID# ______________________________

What Is The Patient's Relationship
To The Cardholder? ______________________________

Permission is hereby granted to Ertel Medicine & Pediatrics to release information to my insurance company, employer, attorney, worker's compensation carrier, physician or facility referred to for further treatment or testing, and/or my referring or family physician. Permission is hereby granted to any facility at which I have been previously treated to release medical records or x-rays to Ertel Medicine & Pediatrics. I consent to treatment by Ertel Medicine & Pediatrics. I understand and agree that I am ultimately responsible for payment, and certify that this information is true and correct. I authorize payment of medical benefits to Ertel Medicine & Pediatrics for services rendered.

Signed ______________________________ Date ______________

MEDICARE PATIENTS ONLY

I authorize payment of Medicare benefits to Ertel Medicine & Pediatrics for services rendered and I authorize the release of medical information to HCFA and its agents

Signed ______________________________ Date ______________