

PATIENT REGISTRATION

Updated Yearly

PATIENT INFORMATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DOB: _____ SS #: _____ SEX: M F HOME #: _____

E-MAIL ADDRESS: _____ Cell #: _____

(By providing your email address you are consenting to Liberty Medical Center staff to use it to send you lab results, and other correspondence regarding your medical care, etc. and realize that emails are not 100% secure.)

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

PATIENT EMPLOYMENT INFORMATION:

EMPLOYER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK #: _____

INSURANCE INFORMATION:

POLICY# _____ GROUP# _____

POLICY HOLDER: _____

PERSON RESPONSIBLE FOR BILL:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DOB: _____ S S #: _____ SEX: M F HOME #: _____

WORK #: _____ RELATIONSHIP TO PATIENT: _____

RESPONSIBLE PARTY EMPLOYER: _____

EMPLOYER PHONE #: _____

EMERGENCY CONTACT:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ WORK #: _____

INSURANCE INFORMATION:

Insurance card/cards must be given at time of service and at any time it is requested by this office. If at any time your insurance changes, please let us know so the proper insurance is filed in a timely manner. If incorrect information is given, you will be responsible for the entire bill.

ALL CO-PAYS AND INSURANCE DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.

I authorize payment of medical benefits to be made directly to Liberty Medical Center.

Signed: _____

Relationship to Patient (If Signed By Guardian): _____ Date: _____

(TURN OVER)