

CARDINAL INTERNAL MEDICINE ASSOCIATES, P.C

REGISTRATION FORM

PATIENT INFORMATION							
PATIENT NAME (PLEASE PRINT)	SEX <input type="checkbox"/> F <input type="checkbox"/> M	DATE OF BIRTH	MARITAL STATUS			AGE	SOCIAL SECURITY NO.
			S	M	W	D	SEP
STREET ADDRESS		CITY, STATE, ZIP CODE				HOME PHONE NUMBER ()	
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)				REFERRED BY		
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP CODE				BUSINESS PHONE NO./EXT. NO. ()		
IN CASE OF EMERGENCY CONTACT (NAME)		RELATIONSHIP			PHONE NO. ()		

INSURANCE INFORMATION			
PRIMARY INSURANCE NAME		SECONDARY INSURANCE NAME	
ADDRESS		ADDRESS	
PHONE NO. ()		PHONE NO. ()	
SUBSCRIBER'S NAME		SUBSCRIBER'S NAME	
SUBSCRIBER'S S.S #	DATE OF BIRTH	SUBSCRIBER'S S.S #	DATE OF BIRTH
RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER:		RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER:	
GROUP NO.	INSURED ID NO.	GROUP NO.	INSURED ID NO.
EFFECTIVE DATE		EFFECTIVE DATE	

1. **AUTHORITY FOR TREATMENT:** I hereby authorize Cardinal Internal Medicine Associates, P.C and/or doctors in charge of the patient to administer such anesthetics and to perform treatment that may be deemed necessary or advisable in the treatment of the patient. I understand that I am liable for the payment of all bills incurred. I agree to pay all attorneys' fees should it become necessary for the filing of a civil suit to collect said claims.

Signature (parent if patient is a minor) _____

2. **RELEASE OF INFORMATION:** I hereby authorize Cardinal Internal Medicine Associates, P.C to release any information pertaining to my health care, test results, billing and/or accounting information to the following person(s) or agencies.

Myself my spouse my insurance company

Other: _____

Signature _____

3. **INSURANCE AUTHORIZATION FOR EXTENSIVE PROCEDURES:** I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Cardinal Internal Medicine Associates and/or the doctor indicated on the claim.

I understand I am financially responsible for any balance not covered by my insurance carrier.

Signature _____

4. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Cardinal Internal Medicine Associates, P.C for any services furnished to me. I authorize the holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for payable related services. Regulations pertaining to Medicare assignment of benefits apply.

Signature _____