West Park Medical Group

Patient Registration and Update Form

PATIENT INFORMATION
(Please Print Clearly)

Patient Name

Last First MI

Sex M ☐ F ☐ | Date of Birth Mo ☐☐ Day ☐☐ 19 Year ☐☐ | Age

Patient's Occupation

Patient's Social Security # ☐☐☐-☐☐-☐☐☐☐

Patient's Address

Street

City State Zip

Home Phone # ( )

Work Phone # ( )

Patient's Employer Name

Phone # ( )

Address

Street

City State Zip

Name of Person to Contact in Case of Emergency

Last First

Relationship

Home Phone # ( )

Work Phone # ( )

POLICY HOLDER INFORMATION

Who is responsible for patient's financial obligations?

Self ☐ Parent/Guardian ☐ Spouse/Sig. Other ☐

Who is Insurance Through: Your Employer ☐

Self Purchased ☐ Spouse/Sig. Other's Employer ☐

Mother's Employer ☐ Father's Employer ☐

Other _____

Name of Policy Holder, if different from the Patient

Last First MI

Policy Holder's Social Security # ☐☐☐-☐☐-☐☐☐☐ and Date of Birth ☐☐-☐☐-☐☐

Policy Holder's Employer Name

Phone # ( )

Address

Street

City State Zip

INSURANCE INFORMATION

Insurance Company Name

Specific Plan Name

Date Insurance Started Mo ☐☐ Day ☐☐ 19 Year ☐☐

Insurance Co. Claims Mailing Address

Street

City State Zip

ID # | Group #

Co-Pay Amount | Deductible Amount, If Any

Primary Care Physician Selected

PLEASE COMPLETE OTHER SIDE OF FORM

Do you have other medical insurance? ☐ Yes ☐ No

If yes, please complete below for other insurance

Insurance Company Name

Specific Plan Name | Primary Care Physician

Date Insurance Started Mo ☐☐ Day ☐☐ 19 Year ☐☐

Insurance Co. Claims Mailing Address

Street

City State Zip

ID # | Group #

Co-Pay Amount | Deductible Amount, If Any

Who is Other Insurance Through:

Please Specify _____

Name: Last First MI

Social Security # ☐☐☐-☐☐-☐☐☐☐ Date of Birth ☐☐-☐☐-☐☐

Chart # Deductible Amount, If Any

Physician Is PCP Verified? Y N

New Patient Y N Is Insurance Verified? Y N

Are Both Sides of Form Completed and Signed? Y N

Are Cards Copied? Y N

A FINANCIAL NOTE:

Please read the following and provide your signature:

1. I have completed the information requested to the best of my knowledge.

2. I authorize the release of information necessary for insurance company billing purposes in the case of assignment of insurance benefits. I understand that in the case of assignment of insurance benefits I may be financially responsible for applicable co-payments, co-insurance, and deductibles, as well as for the cost of services which are not covered by my insurance benefits.

3. I acknowledge that I am financially responsible for all services rendered in the case of non-assignment of insurance benefits.

Patient's Signature _____ Date _____