St. Clair Medical Services

Today's Date: _____

New Patient Registration Form

Patient Demographic Information

Full Legal Name: _____
Last First Middle

Date of Birth: _____ **Sex:** ☐ Male ☐ Female ☐ Other _____
MM / DD / YYYY *Please Specify*

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated **Please Address As:** ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Address:

_____
STREET APT #

_____
CITY STATE ZIP CODE

Phone Number: _____
Please circle preferred: HOME CELL WORK

Email Address: _____

Employment: ☐ Full-Time ☐ Part-Time ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Student Full-Time ☐ Student Part-Time

Employer: _____ **Occupation:** _____

Emergency Contact: _____
Name Relation Phone Number

If Minor, Parent / Guardian: _____
Name Relation Phone Number

Primary Insurance	**Secondary Insurance (If applicable)**
Policy Holder Name _____	Policy Holder Name _____
ID# _____ Group # _____	ID# _____ Group # _____
Address _____	Address _____
Phone # _____	Phone # _____
DOB _____ SS# [optional]_____	DOB _____ SS# [optional]_____
Relationship to Patient _____	Relationship to Patient _____

Workers Compensation/Auto (if applicable)

Name of Insurance Company _____ Phone # _____ Fax # _____
Claim # _____ Date of Injury _____ SS# [optional]_____
Billing Address _____
Adjuster Name _____ Phone # _____
Employer Contact _____ Phone # _____

ASSIGNMENT OF BENEFITS: I hereby assign all medical/surgical benefits to which I am entitled including major medical, Medicare, private insurance or other health plan benefits to the St. Clair Medical Services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment.

MEDICARE: I request that Medicare benefits be made on my behalf to St. Clair Medical Services for healthcare services furnished. I authorize any holder of medical information about me to release to HCFA and its agent any information needed to determine these benefits or the benefits payable for related services; I understand that my signature authorizes the release of medical information needed to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physicians agree to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and any non covered services. Co-insurance and deductible amounts are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Patient or if a minor, Responsible Party Date