Registration Form

Patient Name: ____Date______________________________

Address ____City ______________State _____ Zip _______

Home Phone _(___)_________________ Cell Phone _(___)____________________ Student Yes No

Billing Address ______________________________City _______________State_______ Zip _______

Date of Birth_____/_____/_____ Social Security #______-_____-_____ Gender: Male Female

Marital Status (Please Circle One): Married Single Divorced Widowed Other

Place of Employment/School __________________________Work Phone _(___)__________________

Work Address__________________________________City__________________State______Zip____
If Under 18, guardians name____

May we leave a message for you? Yes No Where at? ____Home ____Work
Is there anybody in your immediate family we can discuss your medical information with? Please provide the names.

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Spouse/Parents Information (If the patient is under 18, please fill out the parent information)
Spouse/Parents Names ________________________ Relationships __________Phone#_(___)_________
Social Security# ____-____-____ Place of Employment____
Work Phone_(___)________________________ **Cell Phone _(___)______________________________**

In Case of Emergency (Someone NOT living with you)
Name:_________________________ Relationship ________________Phone#__(___)_____________
Address______________________________City__________________St_______Zip______________

Insurance Information
Primary Medical Insurance_______________________ Identification #__________________________
Full Name of Policy Holder____
Date of Birth of Policy Holder ____/____/___
Secondary Medical Insurance ____________________ Identification # __________________________
Full Name of Policy Holder____
Date of Birth of Policy Holder ____/____/____

In the event that my physician at Moscow Medical, PA refers me to another health care provider, I hereby authorize the release of any of my medical information to said provider. I understand that if my insurance company does not pay Moscow Medical, PA directly and/or in full for the services provided by Moscow Medical, PA, I assume liability for the unpaid balance on my account with Moscow Medical, PA. I further authorize Moscow Medical, PA to release any information necessary to my insurance company for claims processing purposes. If you have provided our office with your current heath insurance information, we will submit your claims for you. Your insurance company will send payment directly only if that is their policy, and we have agreed to accept assignment.

Signature____Date______________________

I request that payment of authorized Medicare and/or medigap or supplemental insurance benefits be made either to me on my behalf, or to the Moscow Medical, PA for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formally the Health Care Financing Administration, and its agents and/or Medigap or supplemental insurer and its agents any information needed to determine their benefits or benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form (other insurance information) is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept full charge, and the patient is only responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature____Date________________________