

Lifecare Medical Associates, P.C. & Lifecare Diagnostics, Inc.

PATIENT REGISTRATION

Welcome to our office.

In order to serve you properly, we will need the following information. (Please Print)

All information will be strictly confidential.

Patient's Name		Sex M [] F []	Date of Birth	Race	Marital Status Single [] Married [] Widowed [] Divorced []	
Residence address		City	State	Zip	Home Phone:	Patient's Social Security #
Person financially responsible for this account		Self Spouse Parent	Responsible Party's Birthdate		Responsible Party's Social Security #	
Name of employer		Address		Work Phone	Occupation	
Name of Spouse/Parent/Guardian/Significant Other		Sex M [] F []	Birth Date	Social security #	Phone	
Address						
Person to contact in case of emergency:			Relationship to patient		Phone	
Name of Nearest Relative Not Living With You			Relationship to patient		Phone	
Medicare Yes [] No []	Medicare #	Medicaid Yes [] No []	Medicaid #	Effective Date		
Medicare Secondary insurance name		Address		Policy #	Group #	
Workers' Compensation? Yes [] No []	Motor Vehicle? Yes [] No []	Date of Accident	Treatment authorized by	Claim #	W/C or MVA Insurance Phone #	
Primary insurance company					Address	
Subscriber Name					Subscriber birth date	
Secondary insurance name					Address	
Policy #					Group #	

Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Lifecare Medical Associates, P.C. or Lifecare Diagnostics, Inc. for any services furnished me by that physician or facility. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I have completed the form and certify that this information is true and correct to the best of my knowledge.

Patient, Parent or Guardian Signature (if child is under 18 years old)

Date

Note: Please supply Insurance Card(s) so that an image copy can be placed in your file.