ANDERSON MEDICAL GROUP

PATIENT REGISTRATION & DEMOGRAPHICS

Last Name _____ First Name _____ Middle Initial _____

SS# _____Date of Birth _____ Sex: Female, Male or Undifferentiated

Address _____ City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Marital Status ____ Preferred Language _____ Race_____

Ethnicity: (Circle all that apply) Declined to Specify, Hispanic ,Latino,Non-Hispanic or _____

Is it okay to leave voice mail messages with private health information? ___Yes ___No

Email Address for Patient Portal_____

Primary Insurance

Insurance Name _____ Policy # _____ Phone _____

Name of Insured _____ Relationship _____

SS# _____ Date of Birth _____

Employer Name_____ Phone Number_____

Secondary Insurance

Insurance Name _____ Policy # _____ Phone _____

Name of Insured _____ Relationship _____

SS# _____ Date of Birth _____

Communication with Family/ Personal Care Representative/Guardian

Using our best judgment, we may disclose to an immediate family member, other relative or close personal friend, health information relevant to the person's involvement in your care or in an emergency. You may identify specific individual(s) that we may share medical information with verbally, in writing or by phone.

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

I hereby authorize the providers of Anderson Medical Group to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and understand I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. I understand current office policies. I acknowledge receipt of the Notice of Privacy Practices for Anderson Medical Group.

Signature of Patient / Authorized Person_____ **Date** _____