



# PATIENT REGISTRATION FORM

Last Name	First	MI	Female ( ) Male ( )	Birth Date	Age	Home Phone#
Address		Apt#	City	State	Zip	
SS#	Work#	Occupation			Marital Status	
E-Mail	Cell Phone#	Primary Care Physician		Phone#		
Employer Name/Address		City	State	Zip		
Emergency Contact		Relationship		Phone#		

<b>Primary Insurance-Name &amp; Address</b>		
Policy#	Group#	Effective Date
Policy Holder Name	DOB	SS#
Relationship to Patient		

<b>Secondary Insurance-Name &amp; Address</b>		
Policy#	Group#	Effective Date
Policy Holder Name	DOB	SS#
Relationship to Patient		

Is this work related? ( ) Y ( ) N	Date of Injury	Claim#
Workmans Comp. Insurance & Address		
Attorney Name & Address		

## UNIFORM OF ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL DISCLOSURE:

### ASSIGNMENT OF BENEFITS:

I hereby assign or transfer payment benefits made to me and my behalf to Buckeye Medical, Inc. for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid me.

### RELEASE OF INFORMATION:

I hereby authorize Buckeye Medical, Inc. to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor or to an appropriate insurance carrier. If Medicare patient, I further authorize release to the Center of Medicare Services and its agents any information needed to determine benefits payable for related charges.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_