Capital*Care* Medical Group Adult Patient Registration Form

Date: ____________________ **Patient ID#:** __________________
(for office use only)

PATIENT INFORMATION

Social Security Number ________/_____/________ (Providing your SSN is optional. However, for patients with Medicare and/or Medicaid having this information may help us determine eligibility for certain health benefits).

LAST NAME: _____________________________ **FIRST NAME:** ________________________ **MI:** _______

E-mail Address: ____________________________

Street Address: ____

City: __________________________ State: ________ Zip: _________ Home Phone #: (   ) ______________

Work #: (   ) _____________ Cell #: (   ) ______________ Preferred daytime phone: ☐Home ☐ Work ☐ Cell

Date of Birth: ______/______/_______ Marital Status: ☐Single ☐Married ☐Widowed ☐ Divorced

Gender: ☐ Male ☐ Female

It is known that some medical conditions such as high blood pressure and osteoporosis, tend to have a higher incidence in certain ethnic groups. Therefore we ask that you please provide us with information regarding your race and ethnicity so we can assess if you are at increased risk for the development of these conditions.

Race: Select one
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Black/African American
- ☐ White
- ☐ Other

Ethnicity: Select One
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Preferred Language: __________________________

Emergency Contact: __________________________________ Relationship to Patient: ___________________

Emergency Phone #1: (   )____________________________ Phone #2: (   ) _______________________

Primary Care Physician: _____________________________ Referring Physician:______________________
(in our Practice)

In addition to telephone, which other methods of communication are acceptable? Please check all that apply

☐ E-Mail (when available) ☐Confidential Fax ____________________ ☐ Office may leave a message at home

Revised: 12/21/05; 12/2011

Please see reverse side

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MEDICAL INSURANCE INFORMATION

(The subscriber is the same person as the policy holder)

Primary Insurance: ___________________________ Subscriber's Name: _______________________________

Subscriber's Date of Birth: ___/___/___ Relationship to Subscriber: ☐Self ☐Spouse ☐ Child ☐Other _________

Co-pay: $_____________ Policy ID #:___________________________________ Group #: _________________

Secondary Insurance: ___________________________ Subscriber's Name: ______________________________

Subscriber's Date of Birth: ___/___/___ Relationship to Subscriber: ☐Self ☐Spouse ☐ Child ☐Other _________

Co-pay: $_____________ Policy ID #:___________________________________ Group #: _________________

INSURANCE COVERAGE WAIVER

I understand that my eligibility for coverage by the insurance named in the MEDICAL INSURANCE INFORMATION section of this document may not be confirmed at this time. I wish to receive medical services from CapitalCare Medical Group. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

ASSIGNMENT OF INSURANCE BENEFITS / RELEASE OF MEDICAL INFORMATION

I hereby assign to CapitalCare Medical Group (CCMG) any insurance or other third-party benefits available for health care services provided to me. If these benefits are not assigned to CCMG, I agree to forward to CCMG all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt of such payments.

I authorize CapitalCare Medical Group (CCMG) to release the minimum necessary medical or other information to persons employed or retained by or affiliated with CCMG for purposes of my diagnosis and treatment or that may be required in order to process insurance payment. I agree that these provisions will remain in effect until I provide written notice to CCMG that this authorization has been changed or discontinued.

____ ______ /______/________

Signature of Patient / Guardian Date

Please see reverse side