Capital*Care* Medical Group SPECIALIST 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 Are you a current Capital*Care* Patient? □ Yes □ No

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 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

FINANCIALLY RESPONSIBLE PARTY

It is the patient's responsibility to ensure that any required authorization or referral for treatment is provided prior to the time of visit. In the absence of required authorization or referral, the patient's visit may be rescheduled or the patient may be personally responsible for payment for services rendered by Capital*Care* Medical Group.

□ **Check this box if Responsible Party is Adult Patient and same as above.**

LAST NAME: _____**FIRST NAME:** _____

Relationship to Patient: □ Self □ Parent (or Mother/Father) □ Spouse □ Other_____

Address: (□ Same As Above) _____City/State/Zip:_____

Home Phone #: ( ) _____Work #: ( ) _____Cell #: ( ) _____

Date of Birth: _____

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