HouseCall
PRIMARY CARE

Patient Registration Form

Last Name:_____ First Name:_____ Middles:_____ Sex: F M

SS#:_____ DOB:_____ Marital Status: S M W D

Race: Asian White African American Hispanic American Indian Other

Ethnicity: Hispanic Non-Hispanic Language:_____

Address:_____

Daytime Phone:_____ Cell Phone:_____

Emergency Contact:_____ Relationship:_____

Emergency Contact Phone:_____

Preferred Pharmacy and location:_____

Preferred Pharmacy Phone #:_____

Additional Pharmacy and Location:_____

Additional Pharmacy Phone#:_____

Power of Attorney:_____ Relationship:_____

Person Completing this Form:_____ Relationship:_____

Insurance Information

Primary Insurance Co:_____

Subscriber Name:_____ Relationship to Subscriber:_____

Subscriber SS#:_____ Subscriber DOB:_____ Subscriber Phone:_____

Employer Name:_____

ID#:_____ Group#:_____ Effective Date:_____

Claims Address:_____

Secondary Insurance Co:_____

Subscriber Name:_____ Relationship to Subscriber:_____

Subscriber SS#:_____ Subscriber DOB:_____ Subscriber Phone:_____

Employer Name:_____

ID#:_____ Group#:_____ Effective Date:_____

Claims Address:_____

Tertiary Insurance Co:_____

Subscriber Name:_____ Relationship to Subscriber:_____

Subscriber SS#:_____ Subscriber DOB:_____ Subscriber Phone:_____

Employer Name:_____

ID#:_____ Group#:_____ Effective Date:_____

Claims Address:_____

Permission To Contact

Please check your preference:

- ○ Leave lab results on my answering machine or voice mail.
- ○ Leave lab results with my family
- ○ Leave the general questions/medical information on my answering machine or voice mail
- ○ Leave general questions/medical information with a family member
- ○ ONLY leave information with myself
- ○ It is acceptable to mail results to my home

The following people are authorized to discuss my personal medical records, results, treatment options and billing information:

1) _____ Relationship:_____

2) _____ Relationship:_____

3) _____ Relationship:_____

Your signature below allows us to:

1. Accept payment of benefits directly from your insurance company under the terms of your insurance. Release medical records to you insurance, hospitals, any physician, and attorneys for the purpose of determining benefits, coordination of care, or legal matters.
2. Obtain necessary information from your other health care providers.

Your signature below also indicates your acknowledgement that you have been provided with a copy of the Notice of Privacy Practices Policy (HIPAA), and that your answers regarding permission to contact and authorized individuals is accurate.

Signature:_____ Date:_____

Responsible Party Signature:_____ Date:_____