Occu-Med

REGISTRATION

Today's Date		PCP	

PATIENT INFORMATION (Please show your ID to the receptionist)

Patient's Last Name	First	Middle	Mr. Mrs. Miss Ms.	Marital Status (Check One)
				Single Mar Div Sep Widowed

Is this your legal name?	If not, what is your legal name?	(Former Name)	Birth Date	Age	Sex
Yes No					M F

Street Address	City	State	ZIP Code	Social Security	Home Phone No.

Occupation	Employer	Employer Phone No.

How did you learn of our practice?

INSURANCE INFORMATION (Please show your insurance card to the receptionist)

Person Responsible for Bill	Birth Date	Address (if different)	Home Phone No.

Occupation	Employer	Employer Address	Employer Phone No.

Is this patient covered by insurance? Yes No

Please indicate primary insurance	Medicare	Blue Cross	Welfare	Others

Subscriber's Name	Subscriber's S.S. #	Birth Date	Group #	Policy #

Patient's Relationship to subscriber	Self	Spouse	Child

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber	Self	Spouse	Child

Is your current condition related to an accident or work related injury?	No	Yes , If yes please explain below

Are you represented by an attorney?	No	Yes , If yes please answer the following:

Attorney's Name: Attorney's Phone Number:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No.	Work Phone No.

ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to **Occu-Med.** I understand that I am financially responsible for any balance. I also authorize **Occu-Med** or insurance company to release any information required to process my claims. I authorize the use of this signature on all my insurance submissions**.**

PATIENT/GUARDIAN SIGNATURE **Date**

MEDICARE AUTHORIZATION

I request that payments of authorized Medicare benefits insurance is indicated be made on by behalf to **Occu-Med** for any services furnished me by their physical therapists. I authorize any holder of medical information about me to release to the HCFA and its agents any information needed to determine these benefits. I understand my signature requests that the payment be made and authorize the release of medical information necessary to pay the claim. IF other health insurance is indicated in item 9 of the HCFA-1500 FORM, or elswhare on the approved claim forms or eclectroincally submitted claims, my Signature authorizes releasing of the information to the insurance or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge. And the patient is responsible only for the deductible; coinsurance and non covered services, coinsurance, and the deductible are based upon the charge determination of Medicare carrier.

PATIENT/GUARDIAN SIGNATURE Date