St. Clair Medical Services

Today's Date: __________

New Patient Registration Form

Patient Demographic Information

Full Legal Name: ____
Last | First | Middle

Date of Birth: ____________________ MM / DD / YYYY

Sex: ☐ Male ☐ Female ☐ Other ____________________ *Please Specify*

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Please Address As: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Address:
____
STREET | APT #
____
CITY | STATE | ZIP CODE

Phone Number: ____
Please circle preferred: HOME | CELL | WORK

Email Address: ____

Employment: ☐ Full-Time ☐ Part-Time ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Student Full-Time ☐ Student Part-Time

Employer: ______________________ **Occupation:** ______________________

Emergency Contact: ____
Name | Relation | Phone Number

If Minor, Parent / Guardian: ____
Name | Relation | Phone Number

Primary Insurance	Secondary Insurance (If applicable)
Policy Holder Name ______________________	Policy Holder Name ______________________
ID# ______________ Group # ______________	ID# ______________ Group # ______________
Address ______________________	Address ______________________
Phone # ______________________	Phone # ______________________
DOB ______________ SS# [optional]______________	DOB ______________ SS# [optional]______________
Relationship to Patient ______________________	Relationship to Patient ______________________

Workers Compensation/Auto (if applicable)

Name of Insurance Company ______________________ Phone # ______________________ Fax # ______________________

Claim # ______________________ Date of Injury ______________________ SS# [optional]______________________

Billing Address ____

Adjuster Name ______________________ Phone # ______________________

Employer Contact ______________________ Phone # ______________________

ASSIGNMENT OF BENEFITS: I hereby assign all medical/surgical benefits to which I am entitled including major medical, Medicare, private insurance or other health plan benefits to the St. Clair Medical Services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment.

MEDICARE: I request that Medicare benefits be made on my behalf to St. Clair Medical Services for healthcare services furnished. I authorize any holder of medical information about me to release to HCFA and its agent any information needed to determine these benefits or the benefits payable for related services; I understand that my signature authorizes the release of medical information needed to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physicians agree to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and any non covered services. Co-insurance and deductible amounts are based upon the charge determination of the Medicare carrier.

____ ______________________
Signature of Patient or if a minor, Responsible Party | Date