Patient Registration Form
Please fill out **completely**

Office Use Only:
Place sticker here

PATIENT INFORMATION

Name: ______ Sex: Male Female DOB: ______
Last Name First Name MI

Patient Address: ______
Street City State Zip Code

Home Phone: ______ Cell Phone: ______ Work Phone: ______

Patient SSN: ____ - ____ - ____

Primary Care Physician: ______

Email: ______ **[ ] gmail.com [ ] yahoo.com [ ] aol.com [ ] hotmail. com [ ] rochester.rr.com**

How did you hear about us?: ______ **[ ] Family [ ] Friend [ ] Primary Doctor [ ] Online [ ] TV [ ] Other**

Emergency Contact: ______ Relation: ______ Phone: ______

GUARANTOR/RESPONSIBLE PARTY (if patient is under 18)

Name: ______ Sex: Male Female DOB: ______
Last Name First Name

Address: ______
Street City State Zip Code

Relationship to Patient ______ SSN: ____ - ____ - ____

Employer: ______ Work #: ______

Employer Address: ______
Street City State Zip Code

PRIMARY INSURANCE

Subscriber: ______ Sex: Male Female
Last Name First Name

Insured DOB: ______ Insured SSN: ______ Relationship to Patient: ______

Address: ______
(if different from patient) Street City State Zip Code

Plan Name: ______ Insurance Policy #: ______

SECONDARY INSURANCE

Subscriber: ______ Sex: Male Female
Last Name First Name

Insured DOB: ______ Insured SSN: ______ Relationship to Patient: ______

Address: ______
(if different from patient) Street City State Zip Code

Plan Name: ______ Insurance Policy #: ______

Consent for services and/or disclosure of Protected Health Information:

I hereby consent to medical evaluations, testing and/or treatment provided to me by the staff of Accel Care. I also understand that Accel Care may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to Accel Care and agree to pay any remaining balance once my Insurance Plan has processed my claim.

X ______ Date: ______
Signature