TREASURE COAST Primary Care

Patient Registration Form

Date: ____ /____ /_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Last Name: _____ First Name: _____ M.I.: _____

Maiden Name: _____ Birth Date: ____ /____ /_____ Age: _____

☐ Male ☐ Female Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____ Email: _____@_____

Referred by: _____

Ethnicity: (please select) Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline ☐

Race: (please select) White ☐ Hispanic ☐ Black/African American ☐ American Indian/Alaskan Native ☐

Asian ☐ Native Hawaiian/Pacific Islander ☐ **Preferred Language:** _____

Preferred Local Pharmacy: _____

Mail Away Pharmacy: _____

ALL INSURANCE AND SELF PAY PATIENTS: ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT'S ACCOUNT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIERS PAYMENTS; HOWEVER, IF INSURANCE IS DENIED OR INSURANCE INFORMATION IS NOT RECEIVED AT THE TIME OF SERVICE, THE PATIENT/GUARDIAN IS RESPONSIBLE FOR ALL APPLICABLE FEES. IT IS CUSTOMARY TO PAY APPLICABLE CO-PAY CHARGES WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADANCE WITH OUR OFFICE MANAGER.

If visit is to be submitted to an insurance company, please read and initial the following: I request that payment of authorized Medicare/or other Insurance Carrier of benefits be made either to me or on my behalf to Treasure Coast Primary Care for any services furnished to me by that party. Regulations pertaining to Medicare assignments of benefits apply. I authorize any holder of medical or other information about me, to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare/Other Insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical Insurance benefits to the party who accepts the assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S. C3801-3212 provides penalties for withholding this information).

Insurance Information

(Please make sure that the front desk has scanned in a copy of your photo ID and insurance card)

Subscriber's Name: _____ Date of Birth: ____ /____ /_____

Relationship to patient: _____ Phone Number: (_____) _____-_____

Please indicate primary insurance: _____

Please list secondary insurance if applicable: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance that is left over. I also authorize Treasure Coast Primary Care to release any information required to process my claims.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____