Access Medical CLINICS

PATIENT REGISTRATION FORM

PATIENT INFORMATION				
Name: LAST	FIRST	M.I.		Gender ☐ Male ☐ Female
Date of Birth / /	Primary Care Physician (PCP):			
Address:	City:		State:	Zip Code:
Home Phone ( ) -	Alternate Phone ( ) -			
GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR BILL)				
Name: LAST	FIRST	M.I.	Date of Birth / /	
Address:	City:		State:	Zip Code:
Phone Number ( ) -	Relationship to Patient:			
PRIMARY INSURANCE & SUBSCRIBER INFORMATION				
Primary Insurance Name:	Relationship to Subscriber:			
Subscriber's Name: LAST	FIRST	M.I.	Subscriber's Date of Birth / /	
Subscriber ID #	Group #	Plan #	Pharmacy #	
SECONDARY INSURANCE				
Secondary Insurance Name:	Relationship to Subscriber:			
Subscriber's Name: LAST	FIRST	M.I.	Subscriber's Date of Birth / /	
Subscriber ID #	Group #	Plan #	Pharmacy #	
*If patient is a child, who may authorize treatment for this child?	*Relationship to Patient:	Phone Number ( ) -		

I authorize Access Medical Clinics, or its representative, Akamai Practice Management, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Triwest, private insurance, and any other health plan to Access Medical Clinics. 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 understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that I will be assessed the bank charge for each check returned due to insufficient funds. In the event of default, I (We) promise to pay legal interest on the indebtness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note. I hereby authorize Access Medical Clinics to release all information necessary to secure payment and treatment.

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Patient, Parent or Guardian's Signature *Date*