BLUE RIDGE HEALTHCARE

# Patient Registration Form

**PATIENT INFORMATION:** MRN: ORG MRN:

Patient's Legal Name (Last, First, Middle) _____ Nickname: _____

Soc. Security No: _____ Date of Birth: _____ Sex: ☐ M ☐ F

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

Primary Care Physician _____ Home Ph: _____ Cell: _____ Email: _____

Patient's Street Address: _____ City: _____ State: ____ Zip: _____

PO Box: _____ PO Box Zip Code: _____

Employer: _____ Emp. Address (Street, PO Box) _____

City: _____ State: ___ Zip: _____ Employer Phone No. _____ Extension _____

Reason for Visit _____ Who referred you to us? _____

Do we have your permission to leave a voice message (i.e. appointment reminders) at the contact number? ☐ Yes ☐ No

Do we have your permission to leave a voice message for normal test results at the contact number? ☐ Yes ☐ No

**PRIMARY INSURANCE HOLDER / PERSON RESPONSIBLE FOR BILL** ☐ Check here if same as above

Name (Last, First, Middle) _____ Home Ph: _____ Cell: _____ Email: _____

Street Address (Required): _____ City: _____ State: _____ Zip:

PO Box: _____ PO Box Zip Code: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Relationship to Patient: ☐ Parent ☐ Child ☐ Spouse ☐ Self ☐ Other _____

Employer: _____ Emp. Address (Street, PO Box) _____

City: _____ State: ____ Zip: _____ Employer Phone No.: _____ Extension: _____

How are you paying today? ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance ☐ Workman's Comp. ☐ Company Account

## EMERGENCY CONTACT

Name (Last, First, Middle) _____ Home Ph: _____ Cell: _____ Email: _____

Street Address (Required): _____ City: _____ State: _____ Zip: _____

PO Box (if applicable) _____ Employer Phone No.: _____ Extension: _____

Relationship to Patient: ☐ Parent ☐ Child ☐ Spouse ☐ Other _____

## INSURANCE INFORMATION

**Name of Primary Insurance:**

Member/Policyholder (if different from patient): (Last, First, MI)

_____

Member/Policyholder ID#: _____ Date of Birth _____

Insurance Co. Phone No. _____ Group No. _____

Insurance Co. Address (Street Addr. / PO Box)

_____

City: _____ State: ____ Zip: _____

**Name of Primary Insurance:**

Member/Policyholder (if different from patient): (Last, First, MI)

_____

Member/Policyholder ID#: _____ Date of Birth _____

Insurance Co. Phone No. _____ Group No. _____

Insurance Co. Address (Street Addr. / PO Box)

_____

City: _____ State: ____ Zip: _____

## AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND REFERRAL MEDICAL RELEASE

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this informa-tion will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and compliant resolution. I authorize payment directly to this physician practice for all medical or surgical benefits oth-erwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: _____ Date: (Month/Date/Year) _____ / _____ / _____

Office Use Only: (general comments) _____