Advanced Internal Medicine

PATIENT REGISTRATION FORM

PLEASE WRITE LEGIBLY AND COMPLETE ALL SECTIONS

_____ _____

Patient Name Date of Birth

_____

Social Security Number

_____

Street Address City, State, Zip Code

_____Cell Phone Number _____ Home Phone Number

_____ Work/Alternate Phone Number Primary Contact: Cell/Home/Work

Next of Kin (Name and phone number):_____

_____

Pharmacy Name and Phone Number

_____

Email Address (For Web Portal Access)

Insurance:

_____ _____

Primary Name Policy Number

_____ _____

Secondary Name Policy Number

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I hereby authorize representatives of Advanced Internal Medicine to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Advanced Internal Medicine. I certify that the information I have reported with regard to my insurance company coverage is correct.

Signature Date

Health Information Release

I authorize the following person(s) to obtain my personal medical information:

_____ _____

_____ _____

_____

Signature Date