NORTHWEST MEDICAL GROUP

Date: _____
Account: _____
Primary Care Physician: _____ Chart: _____

PATIENT REGISTRATION INFORMATION

Patient: SSN: DOB:
Address: Sex: Phone:
City: St: Zip: Cell:
Marital Status: Employer/School: Emp. Phone:

Responsible Party (Only if Patient is a Dependent)
Name: SSN: DOB:
Address: Sex: Phone:
City: St: Zip:
Relation to Pt: Employer:

Emergency Contact/Guardian
Name: Phone:
Address: Relation to Pt:
Guardian Name:

Insurance Information-Primary
Company: Group: ID:
Subscriber: SSN: DOB:
Address: Sex: Phone:
City: St: Zip: Copay:
Relation to Pt: Employer:

Insurance Information-Secondary
Company: Group: ID:
Subscriber: SSN: DOB:
Address: Sex: Phone:
City: St: Zip: Copay:
Relation to Pt: Employer:

This Office will bill all HMO and PPO contracted payers-copayments and/or Deductibles must be paid at time of visit.

I authorize the release of any medical information necessary to process my claim. I also authorize payment of medical benefits to the physicians or suppliers of services rendered.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible within a 30 day period for all charges whether or not paid by said insurance. I hereby authorize said insurance to release information necessary to secure payment.

Signed: _____ Date: _____