PATIENT REGISTRATION FORM

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

First Name: _____ MI: _____ Last Name: _____

Address: _____Telephone #: (_____)_____

City: _____ State: _____ Zip: _____ Birth Date: _____

Sex: _____ Marital Status: _____ Cell Phone #: (_____)_____

Social Security #: _____ Referring Physician: _____

Patient's Employer: _____ Telephone #: (_____)_____

Address: _____City: _____State: _____ Zip: _____

Contact Preference: (Circle One) Home, Cell, or Other: _____ E-mail Address: _____

Language Spoken: _____ Ethnicity: _____ Race: _____

Pharmacy Name: _____ Pharmacy #: (_____)_____

EMERGENCY CONTACT NAME: **_____**

Address: _____ City: _____State:_____ Zip: _____

Telephone #: (____)_____ Relationship to Patient:_____

****

PRIMARY INSURANCE: **_____ Name of Insured: _____**

Birth Date: _____ Relationship: _____Social Security #:_____

Insured Employer: _____ Address: _____

City: _____State: _____ Zip: _____Telephone #: (_____)_____

SECONDARY INSURANCE: **_____ Insured Name: _____**

Birth Date: _____ Relationship: _____ Social Security #: _____

Insured Employer: _____ Address: _____

City: _____ State: _____ Zip:_____ Telephone #: (_____)_____

AUTHORIZATIONS AND CONSENT FOR TREATMENT: I hereby authorize and consent to treatment given by the physicians and staff of Diabetes & Metabolism Associates, APMC. INSURANCE AUTHORIZATIONS AND ASSIGNMENT: I hereby authorize Diabetes and Metabolism Associates., APMC to furnish information to all insurance carrier(s) concerning my illness and treatments. I hereby assign to the physicians and hospital all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

APPOINTMENT "NO SHOW" POLICY: I understand that I may be subject to a $35.00 charge by Diabetes & Metabolism Associates, APMC for any appointment that is not cancelled 24 hours in advance of the scheduled appointment time.

SIGNATURE: _____DATE: _____

PLEASE BRING THIS COMPLETED PAGE AND HEALTH HISTORY TOGETHER WITH YOUR INSURANCE CARD(S) AND PICTURE ID