INITIAL PATIENT REGISTRATION/INFORMATION SHEET

Today's Date: _____

Patient Information

Name_____
Birthday_____SS# _____
Address_____
City _____ State/Zip_____
Phone No._____
Email _____
Employer_____
Address_____
City _____ State/Zip_____
Phone No._____
Occupation _____
National Origin _____

Spouse/Parent/Guardian Information (circle one)

Name _____
Birthday_____ SS# _____
Address_____
City _____ State/Zip _____
Phone No._____

Employer_____
Address_____
City _____ State/Zip _____
Phone No._____
Occupation _____
National Origin _____

Primary Insurance

Company Name _____
Address_____
City _____State/Zip _____
Phone No. _____
Member's Name _____
Member's DOB _____
Member's Employer _____
Member ID_____Group No. _____

Secondary Insurance

Company Name_____
Address _____
City_____ State/Zip _____
Phone No. _____
Member's Name _____
Member's DOB _____
Member's Employer_____
Member ID_____ Group No._____

In case of emergency, contact:

_____ Relationship _____ Phone _____

I hereby grant permission to the Healthcare Provider on duty to employ such medical, surgical and diagnostic procedures as the doctor may consider necessary in my diagnosis and treatment. I understand that no guarantee or assurance has been made as to the results which may be obtained. I acknowledge and agree that Limestone Medical Center is not responsible for the judgment or conduct of any physician who treats or provides a profession service to me, but rather each physician is an independent contractor who is self-employed and is not the agent, servant, or employee of the hospital.

I authorize the holder of medical or other information to release my insurance carrier, governmental agency or its intermediary, any information needed for this or a related insurance claim. Limestone Medical Center is responsible for filing this claim with my insurance company within a timely manner. However, if correct insurance information is not provided at the time of service, and my insurance denies payment as a result, I understand I am responsible for the full payment of claim denied.

☐ I grant permission to Limestone Medical Center to confirm to my family/friends that I am receiving treatment. (No medical information will be provided.)

☐ I do not grant permission to Limestone Medical Center to confirm to my family/friends that I am receiving treatment.

_____

Signature of patient/parent/legal guardian Date