Independence Park Medical Services

PATIENT REGISTRATION FORM

PATIENT INFORMATION

NAME	DATE OF BIRTH	MARITAL STATUS ☐ S ☐ M ☐ D ☐ W
STREET ADDRESS		APT. NO.

CITY	STATE	ZIP	HOME PHONE
SOCIAL SECURITY NUMBER	AGE	BIRTH GENDER ☐ Male ☐ Female	CELL PHONE
EMPLOYER	OCCUPATION		WORK PHONE
EMERGENCY CONTACT | RELATION TO PATIENT			EMERGENCY CONTACT PHONE

SPOUSE INFORMATION OR PARENT / RESPONSIBLE PARTY INFORMATION

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT ☐ Spouse ☐ Parent ☐ Legal guardian ☐ Other _____
STREET ADDRESS		APT. NO.	HOME PHONE

CITY	STATE	ZIP	CELL PHONE
SOCIAL SECURITY #			DATE OF BIRTH
RESPONSIBLE PARTY EMPLOYER	OCCUPATION		RESPONSIBLE PARTY WORK PHONE/EXT.

ADDITONAL INFORMATION

PREFERED PHARMACY	PRIMARY CARE PHYSICIAN
RACE ☐ White ☐ Black/African American ☐ Indian or Native ☐ Asian ☐ Pacific Islander ☐ Other _____ ☐ Unknown	ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Unreported

PREFERRED LANGAUAGE:

☐ English ☐ Spanish ☐ Other

PERSON(S) AUTHORIZED ACCESS TO YOUR MEDICAL INFORMATION. LIST NAME(S) BELOW:

NAME	DATE OF BIRTH	RELATIONSHIP

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		COPAY	EFFECTIVE DATE
ID (POLICY NO.)	GROUP NO.		
SUBSCRIBER	RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S DATE OF BIRTH
SUBSCRIBER'S EMPLOYER			SUBSCRIBER'S SOCIAL SECURITY NO.

SECONDARY INSURANCE COMPANY		COPAY	EFFECTIVE DATE
ID (POLICY NO.)	GROUP NO.		
SUBSCRIBER	RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S DATE OF BIRTH
SUBSCRIBER'S EMPLOYER			SUBSCRIBER'S SOCIAL SECURITY NO.

Insurance Payment Authorization and Release: I hereby authorize my insurance benefits to be paid directly to the Independence Park Medical Services, Inc. for all medical services rendered to myself or my dependents and acknowledge that I am financially responsible for any services not covered by insurance or unpaid balance. I also authorize the release of any information concerning my illness and treatments requested by my insurance company.

Authorized signature _____ ***Date*** _____