Independence Park Medical Services

PATIENT REGISTRATION FORM

PATIENT MRN#		
NAME	**DATE OF BIRTH**	**MARITAL STATUS** □ S □ M □ D □ W
STREET ADDRESS		**BIRTH GENDER** □ MALE □ FEMALE
TO ACCESS YOUR MEDICAL RECORDS ONLINE THROUGH OUR SECURE PATIENT PORTAL PLEASE PROVIDE YOUR EMAIL ADDRESS BELOW:		**SOCIAL SECURITY NUMBER**
EMAIL ADDRESS:	**EMPLOYER / OCCUPATION**	**HOME PHONE / CELL 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	□ □ Legal Guardian □ Other _____
STREET ADDRESS				**HOME PHONE**
CITY, STATE, ZIP				**CELL PHONE**
SOCIAL SECURITY #				**DATE OF BIRTH**
RESPONSIBLE PARTY EMPLOYER		**OCCUPATION**		**RESPONSIBLE PARTY WORK PHONE/EXT.**

ADDITONAL INFORMATION

PREFERRED PHARMACY	**PRIMARY CARE PHYSICIAN**
RACE □ White □ Black/African American □ Indian or □ Asian □ Pacific Islander □ Other □ Unknown	**ETHNICITY** □ Hispanic or □ Not Hispanic or □ Unknown

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

NAME	**DATE OF BIRTH**	**RELATIONSHIP**

IS THIS VISIT RELATED TO A WORK INJURY? □ YES □ NO	**IS THIS VISIT RELATED TO A MOTOR VEHICLE ACCIDENT? □ YES □ NO**

INSURANCE CARRIER:	**CLAIM NUMBER:**	**DATE OF INJURY/ACCIDENT:**

COMMERCIAL 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*** _____

PLEASE BRING THIS FORM ALONG WITH YOUR INSURANCE CARD(S) AND APPLICABLE COPAY(S) TO YOUR APPOINTMENT. THANK YOU!