

Patient Registration Form

Patient Information	Patient Information:							
	Last Name:		First Name:		M.I.:	Previous Name (if applicable)		
	Mailing Address:			Apt #				
	City/State/Zip:							
	Home Phone:		Cell Phone:		Work Phone:			
	Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) <input type="checkbox"/> Voice <input type="checkbox"/> Text				If Voice, Please Select Preferred Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work			
	Family Physician or Pediatrician:			Date of Birth:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender		
	Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other _____			Social Security #:				
	Employer Name:			Emergency Contact Name:				
	Emergency Contact Phone #:				Relationship to Patient:			
Additional Information and Responsible Party	Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:							
	Last Name:			First Name:				
	Date of Birth:		Social Security #:		Phone:			
	Address of Person Responsible:							
	City/State/Zip:			Relationship to Patient:				
	Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):							
	Email Address:							
	Race (please select): <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Decline			Ethnicity (please select one): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline				
	Preferred Language (please select one):		<input type="checkbox"/> English	<input type="checkbox"/> Bosnian	<input type="checkbox"/> Indian (including Hindi & Tamil)			
			<input type="checkbox"/> Sign Language	<input type="checkbox"/> Spanish	<input type="checkbox"/> Russian	<input type="checkbox"/> Other		
Preferred Pharmacy Name & Location:								
Insurance Information	Primary Medical Insurance			Secondary Medical Insurance				
	Ins. Co. Name			Ins. Co. Name				
	Policy Holder Name:			Policy Holder Name:				
	Policy Holder's Date of Birth:			Policy Holder's Date of Birth:				
	Policy Holder's Social Security #:			Policy Holder's Social Security #:				
	Patient Relationship to Policy Holder:			Patient Relationship to Policy Holder:				
<p>I certify that I have read and agree to Leading Healthcare Clinic payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to LHC all money to which I am entitled for medical expenses related to the services performed from time to time by LHC, but not to exceed my indebtedness to LHC. I authorize LHC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A \$30.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from LHC by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. Comments submitted on surveys may be anonymously shared on the LHC Public Website.</p> <p>MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to LHC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.</p>								

I have reviewed a copy of Leading Healthcare Clinic Privacy Notice. _____ (initials)

Signature of Responsible Party: X _____ Date: _____

Printed Name of Responsible Party: X _____ Date: _____