Acct. #_________

DORAN CLINIC
PATIENT REGISTRATION FORM

Date: _________

Referring Provider: ___________

Name____ Date of Birth __________ SS# ______________

Address: ______________________________________ Marital Status: __ Married __ Single __Widowed __Other

City/State/Zip ______________________________________ Race: _______________ Ethnicity: _________

Home Phone ( ) ___________ Cell Phone ( ) __________ Employment: __Full-time __ Part-time __Self __ Student

Patient Employer: _______________________________________ Phone ( )__________________________

Spouse/Other Name _______________________________ Phone ( ) __________________________

****Have you ever been seen here before today under another name? ____ If so, please list name: _________________**

Emergency Contact

Friend/Relative(**not living with you**) _______________________ Relationship ______________ Phone ( ) ___________

Address: _____________________________________ City/State/Zip_____________________________________

INSURANCE COVERAGE (Primary)

Insurance Company: _______________________________________ Effective Date: _________________

Policyholder’s Name: _______________________ Birth date ________ Patient Relationship: ____________

Policyholder’s Employer: ______________________ Policy #_______________ Group # ________________

INSURANCE COVERAGE (Secondary)

Insurance Company: _______________________________________ Effective Date: _________________

Policyholder’s Name: _______________________ Birth date ________ Patient Relationship: ____________

Policyholder’s Employer: ______________________ Policy #_______________ Group # ________________

Release and Assignment of Benefits

1. I authorize the release of any medical information necessary to process my insurance claim(s).
2. I authorize and request payment for medical services go directly to my physicians.
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me (to include services designated by my insurance company as non-medically necessary, investigational, noncovered, and/or experimental).
4. I agree that a photocopy of this form may be used in lieu of the original.
5. I understand I am financially responsible to Doran Clinic for charges not covered by my insurance (to include services designated by my insurance company as non-medically necessary, investigational, noncovered, and/or experimental).

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of medical information **necessary to process my insurance claim** relating to Mental Health(including depression, mood swings, etc), Substance Abuse (including alcohol/drug abuse), HIV-related information.

ACCEPT: Initials ____ DECLINE: Initials ____

Signature____ **Date** _______________

Parent or Guardian(if under 18) _______________________________________ **Date** _______________

*****By providing us with your wireless/cell phone number, you are hereby granting us, and our agents or independent contractors, your consent to receive calls on your wireless/cell phone number for billing and debt collection purposes.**