Lifecare Medical Associates, P.C. & Lifecare Diagnostics, Inc.

PATIENT REGISTRATION

Welcome to our office.

In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential.

Patient's Name	Sex M [ ] F [ ]	Date of Birth / Primary Language	Race / Ethnicity	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence address City State Zip			Home Phone:	Patient's Social Security # (optional)
Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birthdate		Responsible Party's Social Security # (optional)
Name of employer Address			Work Phone	Occupation
Name of Spouse/Parent/Guardian/Significant Other / Address	Sex M [ ] F [ ] Birth Date		Social security # (optional)	Phone
Person to contact in case of emergency:		Relationship to patient		Phone
Name of Nearest Relative Not Living With You		Relationship to patient		Phone

Medicare Yes **[ ]** No **[ ]**	Medicare #	Medicaid Yes **[ ]** No **[ ]**	Medicaid #	Effective Date
Medicare Secondary insurance name Address			Policy #	Group #

Workers' Compensation? Yes **[ ]** No **[ ]** Motor Vehicle? Yes **[ ]** No **[ ]** **If Yes-put W/C or MVA carrier below**	Date of Accident	Treatment authorized by	Claim #	W/C or MVA Insurance Phone #
Primary insurance company Address				Is insurance through your employer?
Subscriber Name	Subscriber birth date	Policy #		Group #
Secondary insurance name Address			Policy #	Group #

Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Lifecare Medical Associates, P.C. or Lifecare Diagnostics, Inc. for any services furnished me by that physician or facility. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I have completed the form and certify that this information is true and correct to the best of my knowledge.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

Note: Please supply insurance card(s) so that an image copy can be placed in your file.