UK | HIGHLAND
MEDICINE | HOSPITAL

REGISTRATION DOCUMENT

Welcome to our office
Please fill out this form and return to the receptionist

PATIENT NAME & ADDRESS

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ HOME PHONE _____ WORK PHONE _____

NAME PREFERS TO BE CALLED _____ SOCIAL SECURITY # _____

MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED DIVORCED SEPARATED WIDOW
RACE (CIRCLE ONE) WHITE BLACK HISPANIC ASIAN NATIVE AMERICAN UNKNOWN/OTHER

SPOUSE'S NAME (IF MARRIED) _____ SPOUSES WORK OR CONTACT NUMBER _____

SPOUSE EMPLOYER _____

INSURANCE INFORMATION

INSURANCE NAME	SUBSCRIBER	RELATIONSHIP TO SUBSCRIBER	CONTRACT NUMBER	CO-PAY AMOUNT
1)				
2)				

PATIENT INFORMATION

OCCUPATION _____ EMPLOYER _____

EMPLOYER ADDRESS _____ ☐ FULL TIME ☐ PART TIME

PRIMARY CARE PHYSICIAN IN THIS OFFICE _____

OB/GYN DOCTOR _____ PHONE # _____

PHARMACY PREFERENCE _____ PHONE # _____

HAVE YOU BEEN REFERRED BY ANOTHER PHYSICIAN? _____ PHYSICIAN NAME _____

FROM WHOM DID YOU HEAR ABOUT OUR OFFICE? _____

CONTACT IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____ HOME PHONE _____

ADDRESS _____ WORK PHONE _____

AUTHORIZATION STATEMENT

I authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or to the party who accepts assignment. I acknowledge responsibility for payment of fees for all services rendered, regardless of any insurance coverage.

SIGNATURE _____ DATE _____

MEDICARE WAIVER OF LIABILITY

Medicare will only pay for services, which it determines to be medically necessary. Under section 1862 (a) (1) of the Medicare law it states that if the service is not necessary under Medicare program standards, payment will be denied.

I have been notified that Medicare is likely to deny payment for my yearly physical, which Medicare considers preventative care and may not cover. If Medicare denies payment, I agree to be personally and fully responsible for payment.

SIGNATURE _____ DATE _____