**Practice Name:** Wade Dickinson, M.D.



## PATIENT REGISTRATION FORM (Please print)

	First Name:					SSN:				_	
Patient Demographics	Last Name:					Age:	Yrs		Мо		_
	Date of Birth:					Sex:	Male		Female		
	Home Address					Marital Sta	tus:	Single	Married	Widowed	Divorced
	City, State, Zip					Employer:					
	Home Phone:					Occupation	:				
	Cell Phone:					Work Addr					
	Email:					Work Phon	e:				
	Emergency Contact					Emergency					
	Name & Relation:					(diff. than h	nome):				
	First Name:					SSN:		_			
Responsible Party Info (if other than patient)	Last Name:					Age:	Yrs		Мо		
	Date of Birth:					Sex:	Male		Female		
	Home Address					Employer:					
	City, State, Zip					Occupation	:				
	Home Phone:					Work Addr	ess:				
	Cell Phone:					Work Phon	e:				
	Relation to Patient:										
	Primary Insurance Name:					Ins. Card P	rovided:		Yes	No	
Insurance Information	Subscriber Name:					Subsc	riber ID:				
	Insurance Address:					G	roup ID:				
	Subscriber DOB:					PCP A	ssigned:				
	Secondary Insurance Name:					Ins. Card P	rovided:		Yes	No	
	Subscriber Name:					Subsc	riber ID:				
	Insurance Address:										
	Subscriber DOB:						ssigned:				
Consent for Treatment	I hereby give consent for medical or surgical treatment to the attending physician to care for myself or I am duly authorized by the patient as his/her general agent to give consent for such treatment. I hereby give consent for release of medical information to consulting physicians and other medical personnel, as may be required in the rendering of treatment, until I revoke this acknowledgment in writing.										
Financial Respons.	I hereby authorize payment directly to the attending physician of any medical/surgical benefits payable to me under the conditions of my policy for services rendered. I hereby give consent for release to authorized person(s) of financial and medical information concerning care, treatments, and charges as may be required to complete all claims for benefits. I understand that I am financially responsible to the above-named office for the services rendered. In the event of collection action, I shall be responsible for any legal fees incurred. I am aware all co-payment amounts are due at the time of visit and must be paid prior to services rendered. I am aware that I am personally responsible for any and all charges for services not covered under my insurance plan, or deductibles/co-insurance amounts that are due prior to active coverage. I understand that I am financially responsible for any and all costs related to laboratory tests, as part of my medical care, that are rendered and not covered by my current insurance plan. I understand a bill will be issued to me for payment on any unpaid/uncovered services.										
Notice of Privacy Practice	By signing this form I acknowledge I have been given the opportunity to read the Notice of Privacy Practices Policy in its entirety, and been offered a copy of the document. Furthermore, I recognize and understand my rights and the ways my protected health information may or may not be used and/or disclosed in relation to my healthcare and services received.										
How did you hear about our office?		Health Fair	Friend or Family	Insurance Assignment	Online Search	Referral		rred, who referred by?			
Circle your	preferred method of contact	Text	Voicecall	Email	Post Mail						