

Patient Registration

PATIENT NAME		Last	First	Middle
PERMANENT ADDRESS		Street	Apt. No. City	Zip Code
TEMPORARY		Street	City	Zip Code
SOCIAL SECURITY NO.		HOME PHONE (Area Code)		CELL PHONE (Area Code)
AGE	SEX	DATE OF BIRTH	BIRTHPLACE (If born outside of the US)	EMAIL ADDRESS
PLEASE CIRCLE ONE				
Married		Single	Child	Divorced
		Widowed		Separated
EMPLOYER			EMPLOYER/WORK PHONE NO.	
PRIMARY CARE PHYSICIAN			PRIMARY CARE PHONE NO.	
SPOUSE'S NAME (Parent for child)		SPOUSE'S EMPLOYER (Parent for child)		SPOUSE'S SOCIAL SECURITY NO
OTHER – (For child over 18) - Are you a full time student?			Yes	No
			If yes, contact Insurance Co.	
IF VISIT IS FOR INJURY, BE SURE TO INFORM SECRETARY TODAY			DATE OF WORK INJURY:	
NEXT OF KIN (Name of person not living with you to notify if unable to reach you or in the event of an emergency)			PHONE NO.(Area Code)	
<p>MEDICARE B SIGNATURE AUTHORIZATION: I authorize MIMA to release to the Social Security Administration and Centers for Medicare & Medicaid Services, its intermediaries, carriers, or billing agents and any secondary insurance, any information needed for related Medicare claim(s). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.</p> <p>INSURANCE AUTHORIZATION: I authorize MIMA to submit a claim(s) to my primary and secondary insurance carriers, on my behalf, for physician and/or ancillary services. When requested by my insurance company, I authorize MIMA to release all related health care information needed to pay the claim. A photocopy of this authorization may be used in lieu of the original.</p> <p>MIMA respects the rights of patient confidentiality and complies with all HIPAA and other federal privacy regulations. A notice of MIMA privacy policies is available upon request. I acknowledge, by signature below, that I have been made aware of my right to review or obtain a copy of the policies.</p> <p>I have been advised payment is due at time of service. I understand that I will receive itemized statements of my account reflecting the balance pending with insurance and due from me. It remains my responsibility for final payment on my account, regardless of the payment, or lack of payment by my insurance carrier. I accept these arrangements while continuing to receive care and services from Melbourne Internal Medicine Associates (MIMA).</p> <p>This authorization and assignment is to be a continuing one, remaining in force until revoked in writing by the undersigned. I, the signee, agree to the above and acknowledge that this is my current contact information.</p>				
PATIENTS SIGNATURE (Required) _____			DATE _____	
SPOUSE SIGNATURE (Required) _____			DATE _____	
PARENT/TRUSTEE or GUARDIAN (if patient is a minor or unable to sign) _____			DATE _____	
Revised 9/09				

