

# Wilmington Endocrinology Patient Registration Form

PATIENT NAME: \_\_\_\_\_

Last

First

Middle

ADDRESS: \_\_\_\_\_

Street

City

State

Zip

HOME PHONE( ) \_\_\_\_\_ BUSINESS( ) \_\_\_\_\_ CELL( ) \_\_\_\_\_

SOCIAL SECURITY# \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

PLEASE CIRCLE:            MALE or FEMALE

MARITAL STATUS:        MARRIED        DIVORCED        SINGLE        WIDOWED

REFERRING PHYSICIAN: \_\_\_\_\_ REASON FOR YOUR VISIT? \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_ ALLERGIES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

EMPLOYER or SCHOOL: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATION: \_\_\_\_\_ PHONE \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ SSN \_\_\_\_\_

SPOUSE DOB: \_\_\_\_\_ EMPLOYER \_\_\_\_\_

SPOUSE EMPLOYER PHONE # \_\_\_\_\_ ARE YOU INSURED UNDER THEIR POLICY? \_\_\_\_\_

RESPONSIBLE PARTY NAME AND ADDRESS (UNDER 18) \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ SSN \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ EMPLOYER \_\_\_\_\_ PHONE# \_\_\_\_\_

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

#### INSURANCE AUTHORIZATION AND ASSIGNMENT

I request the payment of authorized Medicare/other Insurance Company benefits be made to me or on my behalf to Wilmington Endocrinology; P.A. for any services furnished me by that party who accepts assignment /physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act & 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Signature \_\_\_\_\_ Date \_\_\_\_\_