



Patient Registration Form

Name _____

Last
First
Middle

Address: _____

City
State
Zip

Home #: _____ Cell #: _____ Work #: _____

Primary Care Physician: _____ Referring Physician: _____

Date of Birth: _____

Please Check: Sex: Male Female
 Marital Status: Single Married Divorced Widowed

Social Security #: _____ Employer/School: _____

Employer Address: _____ Employer #: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Spouse Name or Parent/Guardian if Patient is under 18: _____

Relationship to Patient: _____ DOB: _____ SSN: _____

Primary #: _____ Address: _____

Insurance Information (Please present Insurance Card at time of Check-In)

Insurance Information	Primary	Secondary
Name of Insurance Company		
Insurance ID #		
Group ID #		
Name of Policyholder/Subscriber		
DOB of Policyholder/Subscriber		
SSN of Policyholder/Subscriber		

Email: _____ Would you like Patient Portal? Yes No

Ok to Leave a Message at: Home and/or Cell
 Brief Brief
 Extended Extended

Pharmacy: _____ Address: _____ Phone #: _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITIE 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, PA 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 1128D of the Social Security Act & 31 USC 3801-3812 provides penalties for withholding this information.)

Signature: _____ Date: _____