Fill in this form online and click the "Print Form" button, or leave blank and click "Print Form" to fill in by hand in ink. Print Form

CHART # _____ ***EVERY SECTION MUST BE COMPLETED*** **DoctorsCare Patient Registration Form**

Name: _____ Date of Birth: _____ Age: _____ ◯ Male ◯ Female

SSN: _____ Home Phone: _____ Cell Phone: _____

Address: _____ APT# _____

City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____ Marital Status: _____

Emergency Contact: _____ Phone: _____

Insurance Information (If this does not apply, mark N/A)

Insurance Carrier _____ Name of Insured: _____

Policy Holders D.O.B. _____ Sex: _____ Relationship to patient: _____

SSN: _____ Employer: _____ Work Phone: _____

Secondary Insurance Information (If this does not apply, mark N/A)

Insurance Carrier: _____ Name of Insured: _____

Policy Holders D.O.B. _____ Sex: _____ Relationship to patient: _____

SSN: _____ Employer: _____ Work Phone: _____

MEDICARE PATIENTS WITH A SUPPLEMENTAL POLICY: I request that payment of authorized Medigap benefits be made either to me or on my behalf to DoctorsCare for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to (Name of Medigap insurer) _____ any information needed to determine these benefits or the benefits payable for related services. Signature: _____ Date: _____

ACCIDENT INFORMATION: (If this does not apply, mark N/A)

Name, Address, Phone # of Attorney if involved: _____

Is your visit related to: an on the job injury? _____ an automobile accident? _____ Date of Accident: _____

RESPONSIBLE PARTY: (This is either "self" or the parent/guardian with the patient today)

Name: _____ D.O.B. _____ Sex: _____

SSN: _____ Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to patient: _____ Employer: _____ Work Phone: _____

NOTE: PLEASE LIST ANY IMMEDIATE FAMILY MEMBERS WHO ARE PATIENTS HERE FOR COMBINED STATEMENTS:

_____

Permission/Assignment Release

I hereby authorize you to provide necessary medical treatment. I authorize that my insurance benefits be paid directly to **DoctorsCare**. I accept financial responsibility for all unpaid services and authorize **DoctorsCare** to release information as required for patient care and billing purposes. If I should fail to pay my balance, I agreed to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fee to be added and collected by the collection agency immediately upon your default and **DoctorsCare** referral of your account to said collection agency. **I agree that this authorization shall be valid until rescinded in writing when the information is released in reliance upon this consent.** A photocopy of this assignment shall be considered as valid as the original. I have read and fully understand the terms thereof. **Credit Balances of under $20.00 will remain on your account and applied to future visits or we can apply amount due to a credit card.**

Patient OR Guardian Signature: _____ Relationship: _____ Date: _____

If you have filled out this form online, click the "Print Form" button at the top of this page.