PATIENT REGISTRATION FORM

***Today's Date:* _____ *Clinic Name:* Dr Nesbit, PLLC

PATIENT INFORMATION: (Please use full legal name, no nicknames)

***Last Name: _____ *First Name: _____ Middle Initial: _____**

***Address: _____**

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____-_____ *Social Security #: _____

***Date of Birth: _____ Age: _____ *Sex: _____ Marital Status: _____ Drivers Lic#: _____**

***Employer Name and Address: _____**

_____ Work Phone #: (_____) _____-_____

E-mail Address: _____ Cell Phone #: (_____) _____-_____

Emergency Contact Name: _____ Emerg Phone #: (_____) _____-_____

Please tell us how you heard about us: _____Referred by_____

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

***Relationship of Guarantor to Patient: Self _____ Spouse _____ Parent _____ Other _____**

***Last Name: _____ *First Name: _____ Middle Initial: _____**

***Address: _____**

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____-_____ *Social Security #: _____

***Date of Birth: _____ Age: _____ *Sex: Female _____ Male _____**

***Employer Name and Address: _____**

_____ Work Phone #: (_____)_____-_____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name : _____ *Insured's Name: _____

Insured's Social Security #: _____ *Insured's Date of Birth: _____

***Policy / ID #: _____ *Group #: _____ Eff Date: _____**

Claims Address & Phone: _____

SECONDARY INSURANCE:

Plan Name : _____ *Insured's Name: _____

***Insured's Social Security #: _____ *Insured's Date of Birth: _____**

***Policy / ID #: _____ *Group #: _____ * Eff Date: _____**

Claims Address & Phone: _____

***REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS.**

Please read and sign back of form.

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: _____ **Date of Birth:** _____
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Dr Nesbit, PLLC or the physician who individually rendered to myself or my dependents. I understand that is my responsibility to know my insurance benefits and whether or not services I receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due to Dr. Nesbit, PLLC.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that my information given for applying for payment is correct. I authorized the release of any of my or my dependent's Records to the programs that may requested. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Dr. Nesbit, PLLC or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that my information given for applying for payment is correct. I authorized the release of any of my or my dependent's Records to the programs that may requested. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Dr. Nesbit, PLLC or the physician on my behalf.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of mail, text, phone calls and email. I hereby authorize Dr. Nesbit, PLLC or any of it's representatives or my physician to mail, email or call communications regarding my health care including but not limited to such things as appointment reminders, arrangements, Health care coordination and results of testing. I understand that I have the right to rescind this authorization at anytime notifying Dr. Nesbit, PLLC to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if any of my medical care includes lab, x-ray or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my physician at Dr. Nesbit, PLLC or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If different from patient)

GUARANTOR NAME (Please Print): _____