Carolinas Physicians Network
Carolinas HealthCare System

# Patient Registration Form

## PATIENT INFORMATION: MRN: ORG MRN:

Patient's Legal Name (***Last***, *First, Middle)* | Nickname

Social Security Number | Date of Birth | Sex M F | Marital Status ☐ Divorced ☐ Single ☐ Married ☐ Widowed ☐ Separated

Primary Care Physician | Home Phone Number

Patient Street Address *(Required)* | Cell Phone Number

City | State | Zip *(+4 if known)* | E-Mail Address

P.O. Box | P.O. Box Zip Code

Employer Name | Employer Phone Number | Extension

Employer Address *(Street, P.O. Box)* | City | State | Zip Code

Reason for Visit | Who referred you to us?

Do we have your permission to leave a voice message (i.e. appointment reminders) at the contact number? ☐ Yes ☐ No
Do we have your permission to leave a voice message for normal test results at the contact number? ☐ Yes ☐ No

## PRIMARY INSURANCE HOLDER / PERSON RESPONSIBLE FOR BILL:

☐ *Check Here if Same As Above*

Name (***Last***, *First, Middle)* | Home Phone Number

Street Address *(Required)* | P.O. Box | P.O. Box Zip Code

City | State | Zip *(+4 if known)* | Social Security Number

Date of Birth | Sex M F | Relationship ☐ Child ☐ Self ☐ Spouse ☐ Other _____

Employer Name | Work Phone Number | Extension

Employer Street Address *(Required)*

City | State | Zip *(+4 if known)*

**How are you paying today?** ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance ☐ Workman's Comp. ☐ Company Account

## EMERGENCY CONTACT:

Name (***Last***, *First, Middle)* | Home Phone Number

Street Address *(Required)* | P.O. Box *(if applicable)*

City | State | Zip *(+4 if known)* | Work Phone Number | Extension

Relationship ☐ Child ☐ Spouse ☐ Other _____ | Cell Phone Number



***PLEASE COMPLETE BACK OF FORM***

## INSURANCE INFORMATION:

**Please complete the section below.**

| **Name of Primary Insurance** | | | **Name of Secondary Insurance** | | |
|---|---|---|---|---|---|
| Member/Policyholder (if different from patient): *(Last, First, MI)* | | | Member/Policyholder (if different from patient): *(Last, First, MI)* | | |
| Member/Policyholder ID# | Date of Birth | | Member/Policyholder ID# | Date of Birth | |
| Insurance Co. Phone Number | Group # | | Insurance Co. Phone Number | Group # | |
| Insurance Co. *(Street Address/P.O. Box)* | | | Insurance Co. *(Street Address/P.O. Box)* | | |
| *(City)* | *(State)* | *(Zip Code)* | *(City)* | *(State)* | *(Zip Code)* |

## AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND REFERRAL MEDICAL RELEASE:

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and compliant resolution. I authorize payment directly to Carolinas Physicians Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: _____ Date _____ / _____ / _____

***Office Use Only:***
General Comment Section: