MY DOCTOR
REGISTRATION FORM

☐ New ☐ Changed

REFERRAL

Referral Name: _____
☐ Yellow Pages ☐ Doctor
☐ Friend/Relative ☐ Other

PATIENT INFORMATION

PATIENT NAME (Last, First, MI)			TELEPHONE (Home)		TELEPHONE (Mobile or Other)
E-MAIL Address			EMPLOYER NAME		TELEPHONE (Work)
ADDRESS			EMPLOYER ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
DATE OF BIRTH	SEX ☐ Male ☐ Female	SOCIAL SECURITY NUMBER	EMPLOYMENT STATUS ☐ Full-Time ☐ Retired ☐ Part-Time ☐ Not Employed	PATIENT STUDENT STATUS ☐ Full-Time ☐ Part-Time If 19 Years or Older: ☐ Not a Student	
MARITAL STATUS ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single	AGE	EMERGENCY CONTACT Name: _____ Relationship: _____ Phone: _____ Cell Phone: _____			

RESPONSIBLE PARTY FOR BILLING (IF DIFFERENT THAN PATIENT)

RESPONSIBLE PARTY NAME (Last, First, MI)			SOCIAL SECURITY NUMBER	PATIENT RELATIONSHIP TO RESPONSIBLE PARTY ☐ Self ☐ Spouse ☐ Child Other: _____
RESPONSIBLE PARTY ADDRESS (Street, Apt.No.)			EMPLOYER NAME	TELEPHONE (Work)
CITY	STATE	ZIP	EMPLOYER ADDRESS (Street, Apt. No.)	
TELEPHONE (Home)	TELEPHONE (Emergency)		CITY	STATE ZIP

INSURANCE

PRIMARY INSURANCE IN WHOSE NAME?			DATE OF BIRTH	PATIENT RELATIONSHIP TO INSURED PARTY ☐ Self ☐ Spouse ☐ Child Other: _____
PRIMARY INSURANCE CARRIER	TELEPHONE	GROUP NUMBER	POLICY ID NUMBER	Does your primary insurance require a referral to see a specialist? ☐ Yes ☐ No
SECONDARY INSURANCE IN WHOSE NAME (As on ID card)?			DATE OF BIRTH	PATIENT RELATIONSHIP TO INSURED PARTY ☐ Self ☐ Spouse ☐ Child Other: _____
SECONDARY INSURANCE CARRIER	TELEPHONE	GROUP NUMBER	POLICY ID NUMBER	Does your secondary insurance require a referral to see a specialist? ☐ Yes ☐ No

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. I authorize MY DOCTOR to render needed treatment to the above named patient.
2. I authorize MY DOCTOR to release any medical or other information, as required in the course of examination or treatment, to process patient's claims. I also request payment of government benefits to either MY DOCTOR, who accepts assignment, or myself.
3. I authorize my insurance or Medicare benefits to be paid directly to the treating physician. I understand that I am responsible for charges not covered by my insurance.
4. I understand that I am responsible for all charges incurred through MY DOCTOR. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.
5. In Medicare assigned cases, MY DOCTOR agrees to accept charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

LEGAL SIGNATURE	DATE	LEGAL SIGNATURE	DATE
1 _____	_____	3 _____	_____
2 _____	_____	4 _____	_____