

THE COLLIS GROUP

DATE OF APPOINTMENT _____ PATIENT REGISTRATION FORM
PLEASE PRINT - MUST BE FILLED OUT COMPLETELY

ACCT #: _____

NAME: _____
(PREFIX) (FIRST) (M.I.) (LAST) (SUFFIX)

ADDRESS: _____ COUNTY: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: (____) _____

AGE: _____ BIRTHDATE: _____ SEX: _____ SOCIAL SECURITY NUMBER: _____

STATUS: CHILD SINGLE MARRIED DIVORCED WIDOWED

How Did you hear about us?

OPATIENT OPHONE BOOK OPHYSICIAN OINS. CO OEMERGENCY ROOM OADVERTISEMENT

EMPLOYED BY: _____ OCCUPATION: _____

STATUS: FULL-TIME UNEMPLOYED RETIRED DISABLED PART-TIME SELF EMPLOYED

EMPLOYER'S ADDRESS: _____

PHONE: (____) _____

May we call you at work? No Yes NAME OF SPOUSE, PARENT, OR GUARDIAN: _____

EMPLOYED BY: _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ PHONE: (____) _____

REFERRING PHYSICIAN - _____ PHONE: (____) _____

ADDRESS: _____ CITY _____ STATE _____ ZIP: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: (____) _____

ADDRESS _____ CITY: _____ STATE: _____ ZIP: _____

Who May we contact in case of emergency? _____ *Relationship to Patient* _____

Address _____ *Phone:* _____

_____ IS THIS VISIT

RELATED TO A WORK RELATED INJURY? NO YES AUTO ACCIDENT? NO YES

IF YES, NAME OF ATTORNEY _____

ADDRESS: _____ PHONE: (____) _____

OTHER ACCIDENT? NO YES IF OTHER ACCIDENT, PLEASE SPECIFY: _____

PRIMARY INSURANCE INFORMATION
NOTE: PLEASE GIVE RECEPTIONIST INSURANCE CARDS TO PHOTOCOPY

NAME OF INSURANCE COMPANY: _____ PHONE: (____) _____

CLAIMS : ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME OF INSURED: _____ SUBSCRIBER'S SS#: _____ CO-PAYMENT AMT \$ _____

DOB OF SUBSCRIBER _____ CERTIFICATE OR ID#: _____ RELATIONSHIP TO PATIENT _____

GROUP #.: _____ REFERRAL NO.: _____ # OF VISITS _____

POLICY EFFECTIVE DATE _____

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY _____ PHONE (____) _____

CLAIMS

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER'S SS#: _____ DATE OF BIRTH OF SUBSCRIBER _____

CERTIFICATE OR ID#: _____ GROUP#: _____ POLICY EFFECTIVE DATE: _____

I authorize the release of any medical information necessary to process this claim. I understand that I am responsible for all co-payments, co-insurance, and services deemed "non-covered" by my insurance company. I also authorize payment of medical benefits directly to the physician for services rendered.

PATIENT: _____ PARENT, IF MINOR: _____