

I.D. CONSULTANTS, P.A. PATIENT REGISTRATION FORM

All patients must complete our Registration and Coverage Verification Forms before seeing the doctor.

Referring M.D. _____ Referring M.D. Phone # (____) _____ -- _____

Primary Care M.D. _____ Primary Care M.D. Phone # (____) _____ -- _____

Social Security # _____ -- _____ -- _____ Emergency Contact _____

PATIENT NAME (Last, First, Middle) _____

Address _____ Zip _____ City _____ State _____

Home Phone (____) _____ -- _____ **(Please note we make appointment reminder calls.)**

Mobile Phone (____) _____ -- _____ Date-of-Birth ____/____/____ Gender: M F

Email _____ **(Please do not provide if you wish for us to never use it.)**

* Employer _____ Work Phone (____) _____ -- _____

Employer Address _____ Zip _____ City _____ State _____

GUARANTOR Name _____ Date-of-Birth ____/____/____

GUARANTOR Social Security # _____ -- _____ -- _____ **Guarantor** Gender: Male Female

GUARANTOR EMPLOYER _____

Is this is a Worker's Comp claim? _____ If so, what is the Date of Injury? ____/____/____

If so, who at your company can verify that this is a Worker's Comp claim? _____

If so, who is the Worker's Comp Insurance contact? Claim #? _____

I certify I am covered under the following insurance companies: 1-Primary _____

2-Secondary _____ 3-Tertiary _____

I authorize the release of medical and/ or other information necessary to process insurance claims and the assignment of benefits directly to I.D. Consultants, P.A. for services already rendered or will be rendered in the course of my patient relationship with I.D. Consultants, P.A.. I also authorize representatives of this Practice to aid in obtaining reimbursement from my insurance companies, including appealing any denials to my health plan. I understand that this Practice will file my insurance as a courtesy but in no way can guarantee payment from my insurance for medical services rendered; thus, I will be ultimately responsible for payment. I also understand that if reimbursement is reduced or denied for partially- or non-covered services, I will be responsible for payment.

Patient Signature

_____/____/____
Date

*Responsible Party Signature

_____/____/____
Date

Printed Name of Responsible Party

(*If the Responsible Party Signature is not completed, the Patient is the Responsible Party.)