

Date: _____

REGISTRATION UPDATE

All patients must update our Registration Forms before seeing the doctor.

PATIENT NAME (Last, First, Middle) _____

Date of Last Visit with ID Consultants, PA _____ Doctor _____

Social Security # _____ -- _____ -- _____ Date-of-Birth ____/____/____

Address _____ City _____ State _____ Zip _____

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

Mobile Phone (_____) _____ -- _____ Emergency Contact _____

➤ Has your employer changed since your last visit? YES NO
If so, please list your new information:

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

Employer Address _____ City _____ State _____ Zip _____

➤ Has your insurance information changed since your last visit? YES NO
If so, please list your new insurance information and notify the registration desk:

Primary: Policy Number:

Secondary: Policy Number:

Tertiary: Policy Number:

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. 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.)

We accept Cash, Checks, Visa / Mastercard, & American Express