

Patient Pre-Registration Form

Please fill out this form as completely as possible. This completed form will save valuable time for both you and the office upon your arrival.

Name of Patient	<input type="text"/>	Prescribing	<input type="text"/>
Address	<input type="text"/>	Phone:	<input type="text"/>
City, State, Zip	<input type="text"/>	Primary Care Doctor	<input type="text"/>
Phone	<input type="text"/>	Phone	<input type="text"/>
Date of Birth	<input type="text"/>	Age	<input type="text"/>
Sex	<input type="text"/> M <input type="text"/> F	Employment status	<input type="text"/>
SS #	<input type="text"/>	Patient's employer	<input type="text"/>
Cell Phone	<input type="text"/>	Address	<input type="text"/>
E-Mail Address:	<input type="text"/>	Phone	<input type="text"/>

Email address is for a patient newsletter and will not be used for any third party or spam. We will never share, sell, or rent individual personal information with anyone without your advance permission or unless ordered by the court of law. Information submitted to us is only available to employees managing this information for purposes of contacting you or sending you emails based on your request for information and contracted services providers for purposes of containing you sending you emails based on your request for information and to contracted services for purposes of providing services relating to our communications with you.

Emergency Contact: Emergency Contact Phone:

PRIMARY INSURANCE INFORMATION

Insurance Carrier:	<input type="text"/>		
Other Carrier:	<input type="text"/>	Name of Card Holder:	<input type="text"/>
ID#	<input type="text"/>	SS# of Card Holder:	<input type="text"/>
Group#	<input type="text"/>	D.O.B. of Card Holder:	<input type="text"/>
Insurance Address:	<input type="text"/>	Employer:	<input type="text"/>
Phone:	<input type="text"/>	Phone:	<input type="text"/>
Relationship to patient <input type="text"/> Self <input type="text"/> Spouse <input type="text"/> Mother <input type="text"/> Father <input type="text"/> Other <input type="text"/>			

SECONDARY INSURANCE INFORMATION:Insurance Carrier: Other Carrier: ID# Group# Insurance Address: Phone: Name of Card Holder: SS# of Card Holder: D.O.B. of Card Holder: Employer: Phone: Relationship to patient: Self Spouse Mother Father Other _____

TERTIARY INSURANCE INFORMATIONInsurance Carrier: Other Carrier: ID# Group# Insurance Address: Phone: Name of Card Holder: SS# of Card Holder: D.O.B. of Card Holder: Employer: Phone:

Relationship to patient: __ Self __ Spouse __ Mother __ Father __ Other _____

EARLY INTERVIEW/ DSCC/ MEDICADPlease select your insurance carrier: Case Worker's name: Phone Fax

WORKMAN'S COMPENSATION

IF THIS IS A WORKMAN'S COMPENSATION CLAIM, PLEASE ANSWER THE FOLLOWING:

DATE OF INJURY* CLAIM#* CASE WORKERS NAME* PHONE*

EMPLOYER* _____

FAX* _____

MEDICARE INFORMATION

Why are you eligible for Medicare?

__Age __ Disability __ End stage renal disease __ Date Dialysis began ____/____/____

If you have insurance through another source and the insured is still working, we need to know how many people are employed in that company: __ 0-24 __ 25-99 __ 100+

I AUTHORIZE THE RELEASE OF ANY INFORMATION ABOVE NECESSARY TO PROCESS MY INSURANCE AND AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO EXPRESS MEDICAL SUPPLY, INC. PAYMENT IN FULL IS REQUIRED AT THE TIME SERVICES ARE RENDERED. IF PRIMARY INSURANCE IS ACCEPTED, ALL OPEN DEDUCTIBLES AND CO-INSURANCE FEES WILL BE COLLECTED FROM THE PATIENT AT THE TIME OF THE VISIT. ALL FEES NOT COVERED BY OUR COLLECTED FROM INSURANCE CARRIER WILL BE THE PATIENT RESPONSIBILITY.

SIGNATURE: _____ DATE: _____