

LOGAN PRIMARY CARE SERVICE

PATIENT REGISTRATION

Account # Employee Use Only DATE - - .

Name: Last First Middle Int.

Nickname: Date of Birth: - - Sex: **M** **F**

Address: Street City State Zip

Phone No: Work Phone: SS#

Employer: Occupation:

Marital Status: **S M W D** Spouse's Name: D.O.B. - -

Spouse's Employer: Work Phone:

Personal Physician: Referring Physician:

******If Patient is a Minor, Please Complete The Following******

Responsible Party: Name Date of Birth: - -

Relationship to Patient: S.S.#

Address (If different from above):

Home Phone: Work Phone:

******Insurance******

Do You Have Health Insurance? **YES NO** If Yes, please present insurance cards at registration.

Is Precertification required by your insurance? **YES NO**

Is this a Worker's Compensation Injury? **YES NO** If Yes, please fill out Worker's Compensation Form.

I request that payment of authorized Medicare benefits and/or personal insurance be made either to me or on my behalf to the Logan Primary Care Clinic for any services furnished to me by my Physician in person or under his supervision.

I authorize the release of any and all medical information requested by the Health Care Financing Administration or its agents or any other party or insurance carrier entitled to information regarding my illness, accident, and/or treatment.

I authorize the use of electronic recordings by the Physician to help insure accuracy of my medical record.

I hereby agree to pay any bill on my account that has had no payment activity within the last 60 days , and to pay all fees related to the collection of monies owed on my account including, but not limited to, collection agency fees, attorney fees and/or court costs, including filing fees.

X
Patient/Guardian Signature Date



Caring is our Specialty

