Registration and Consent for Services

Choices for Health, PC
Gayle Hand, ANP

_____ _____ _____ _____ _____ M / F

PATIENT LAST NAME | FIRST NAME | MIDDLE | BIRTH DATE | AGE | SEX

_____ _____ _____ _____ (_____)_____

CURRENT STREET ADDRESS | CITY | STATE | ZIP | HOME PHONE

_____ (_____)_____

MAILING ADDRESS IF DIFFERENT | WORK PHONE / EXT

_____ (_____)_____

E-MAIL ADDRESS | CELL PHONE

_____ _____FT / PT _____

EMPLOYER/SCHOOL IF STUDENT | OCCUPATION | EMPLOYER ADDRESS

_____ _____ _____

DRIVERS LICENSE/ STATE | PREVIOUS MEDICAL PROVIDER | REFERRED BY

M S W D O _____ _____ _____

MARITAL STATUS | SPOUSE/PARTNER NAME | SPOUSE/PARTNER EMPLOYER | OCCUPATION

_____ _____ (_____)_____

EMERGENCY CONTACT NAME / ADDRESS | RELATIONSHIP | PHONE NUMBER

INSURANCE INFORMATION

_____ _____ _____

PRIMARY INSURANCE NAME | PRIMARY INSURANCE ADDRESS | PHONE NUMBER

_____ _____ _____ _____

SUBSCRIBER'S NAME | BIRTH DATE | SUBSCRIBER'S ID # | GROUP #

_____ _____SELF _____SPOUSE _____OTHER

SUBSCRIBER'S ADDRESS / PHONE IF DIFFERENT THAN ABOVE | RELATIONSHIP TO PATIENT

_____ _____ _____

SECONDARY INSURANCE NAME | SECONDARY INSURANCE ADDRESS | PHONE NUMBER

_____ _____ _____ _____

SUBSCRIBER'S NAME | BIRTH DATE | SUBSCRIBER'S ID | GROUP#

_____ _____SELF _____SPOUSE _____OTHER

SUBSCRIBER'S ADDRESS / PHONE IF DIFFERENT THAN ABOVE | RELATIONSHIP TO PATIENT

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I have read the Choices for Health, PC Office Policy and Information Sheet. I understand that I am financially responsible for all charges for the services rendered to me. I authorize release of any information necessary to process my insurance claims and I hereby authorize payment of benefits to me to be made directly to Gayle Hand, ANP/Choices for Health, PC. I understand that some charges may be denied by Medicare and I will be responsible for payment.

SIGNATURE: _____ DATE: _____