MID-MICHIGAN PHYSICIANS, P.C.
PATIENT REGISTRATION FORM – 2009

PERSONAL INFORMATION	
NAME:	**RESPONSIBLE PARTY OR PERSON RESPONSIBLE FOR MINOR (UNDER THE AGE OF 18)**
ADDRESS:	NAME:
	DOB: SSN:
HOME PH: CELL PH:	RELATIONSHIP TO PATIENT:
WORK PH:	ADDRESS:
PATIENT DOB: SEX:	
SSN: MARITAL STATUS:	HOME PH: CELL PH:
PATIENT MRN/ACCOUNT #:	WORK PH:
EMPLOYMENT STATUS: □ **Full Time** □ **Part Time** □ **Not Employed** □ **Self Employed** □ **Retired** □ **Military Duty** □ **Disabled**	EMPLOYMENT STATUS: □ **Full Time** □ **Part Time** □ **Not Employed** □ **Self Employed** □ **Retired** □ **Military Duty** □ **Disabled**
EMPLOYER:	EMPLOYER:
ADDRESS:	ADDRESS:

INSURANCE INFORMATION	
PRIMARY INSURANCE INFORMATION	**SECONDARY** INSURANCE INFORMATION
COMPANY:	COMPANY:
GROUP # :	GROUP #:
POLICY #: SUFFIX:	POLICY #: SUFFIX:
SUBSCRIBER: DOB:	SUBSCRIBER: DOB:

EMERGENCY CONTACT	
NAME:	HOME PH:
ADDRESS:	WORK PH:
	CELL PH:

REFERRAL INFORMATION	
REFERRING DOCTOR:	PRIMARY CARE DOCTOR:
ADDRESS:	ADDRESS:

INSURANCE AUTHORIZATION INFORMATION

MEDICARE PATIENTS: I request payment of authorized Medicare benefits made either to me or on my behalf to Mid-Michigan Physicians, P.C. for any services furnished to me by them. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits for related services.

Signature: _____ Date: _____

MANAGED CARE PATIENTS: (PHP, BCN, Etc.) I understand that I am personally responsible for getting any authorizations required from my primary care physician before services are rendered, and failure to do so will result in my being held responsible for payment in full when services are rendered.

Signature: _____ Date: _____

I hereby authorize any treatment and care given and will be financially responsible for non-covered services. I am responsible for knowing what my insurance limitations are.

Signature: _____ Date: _____

I authorize the release of medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

revised 08/2009