PATIENT REGISTRATION – GALEN MEDICAL GROUP, PC

PATIENT INFORMATION:

NAME: _____ GENDER: ❑ Male ❑ Female

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

PRIMARY PHYSICIAN: _____ REFERRING PHYSICIAN: _____

PATIENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE :(____) _____

WORK PHONE: (_ _ ___) _____ CELL PHONE: (_ ___) _____ E-MAIL _____

PATIENT EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____
Street / P.O. Box / Apt. No. City / State / Zip Code

May we leave lab, testing results and appointment reminders on your home answering machine? ❑ Yes ❑ No

CELL PHONE? ❑ Yes ❑ No EMAIL? ❑ Yes ❑ No _____
Patient Signature

SPOUSE INFORMATION:

NAME: _____ DATE OF BIRTH: _____

EMPLOYER: _____CELL PHONE: _____ WORK PHONE: _____

EMPLOYER ADDRESS: _____
Street / P.O. Box / Suite # City / State / Zip Code

EMERGENCY CONTACT INFORMATION:

NAME: _____ HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____
Street / P.O. Box / Apt. No. City / State / Zip Code

INSURANCE INFORMATION:
We Require Copies Of ALL Insurance Cards In Order To File Your Insurance Claims.

PRIMARY INSURANCE: _____INS ID#:_____ RELATIONSHIP TO SUBSCRIBER: _____

SUBSCRIBER'S NAME: _____ SS#:_____ DOB: _____
(EXACT Name Listed On Card.) (REQUIRED By ALL Insurance Carriers)

ADDITIONAL INSURANCE:

SECONDARY INSURANCE: _____ INS ID#:_____ RELATIONSHIP TO SUBSCRIBER: _____

SUBSCRIBER'S NAME: _____ SS#:_____ DOB: _____
(EXACT Name Listed On Card.) (REQUIRED By ALL Insurance Carriers)

ADVANCED DIRECTIVES:

It is the right of every adult citizen in Tennessee (18 years and over) to sign a Living Will, as well as a Durable Power of Attorney for Health Care that empowers an Individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices you make in your Living Will will be binding on doctors, hospitals, and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure your provider has a copy for your file.

AUTHORIZATION:

I authorize Galen Medical Group, PC to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Health Care Financing Administration, third Party Administrators, and/or Workers' Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize Galen Medical Group, PC to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to Galen Medical Group, PC to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities.

I request that payment of Medicare, MediGap, Traveler's Railroad Retirement, Managed Care Organization, Third Party Administrators, Commercial, Workers' Compensation, Liability, and/or any other insurance benefits be made on my behalf to Galen Medical Group for services furnished to me or on my behalf by that provider.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between Galen Medical Group and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

_____ _____ _____
Signature of Patient ***Date*** ***Signature of Responsible Party/Insured***

PLEASE COMPLETE THE ADDITIONAL INFORMATION ON THE BACK OF THIS SHEET

PLEASE COMPLETE THE FOLLOWING IF YOU ARE COVERED UNDER MEDICARE:

Medicare law requires that we determine if your medical services might be covered by another insurer.
In order to assist us in the correct billing of your services, please answer the following questions:

Are you employed? ❑ Yes ❑ No Retirement Date: _____

Is your spouse employed? ❑ Yes ❑ No Retirement Date: _____

If you or your spouse is employed, please complete the health plan information on the front of this form.

Are you eligible for coverage under the Veteran's Administration ❑ Yes ❑ No

Are you eligible for coverage under Worker's Compensation? ❑ Yes ❑ No

Is your injury/illness due to an automobile accident? ❑ Yes ❑ No

If yes, please complete the following:

Auto Insurance Name & Address: _____

Name(s) of Insured: _____ Policy or ID#: _____

Accident Date: _____ Accident Location: _____

PREFERRED LANGUAGE: Please list one. _____

PATIENT ETHNICITY: Please select one. ❑ Hispanic or Latino ❑ Non-Hispanic or Non-Latino

PATIENT RACE: Please select one or more. ❑ African American ❑ American Indian or Alaska Native ❑ Asian

❑ Caucasian/White ❑ Native Hawaiian or Other Pacific Islander ❑ Other

IF SERVICES ARE BEING PROVIDED TO YOUR DEPENDENT, PLEASE COMPLETE THE FOLLOWING:

MOTHER'S NAME: _____ DOB: _____ SS#: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____ CELL PHONE: (_____) _____

FATHER'S NAME: _____ DOB: _____ SS#: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____ CELL PHONE: (_____) _____

I hereby authorize Galen Medical Group, its physicians and staff, to render appropriate medical care to my dependent listed under patient information on the front of this form.

_____ _____

Signature of Responsible Party ***Date***

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, grant permission for the person(s) listed below to have access to any and all of my medical information that pertains to my care from the physicians of this group. This includes, but is not limited to, appointment times, lab results, my physician's plans for health care, etc.

Signature: _____

Name: _____Relationship: _____ Phone: (_____) _____

Name: _____Relationship: _____ Phone: (_____) _____

Name: _____Relationship: _____ Phone: (_____) _____

I AGREE TO NOTIFY GALEN MEDICAL GROUP, IN WRITING, IF THERE ARE ANY CHANGES IN THE PERSON(S) AUTHORIZED

THANK YOU