Patient Registration	
CURRENT PATIENT INFORMATION	**PHARMACY/INSURANCE INFORMATION**
Last Name:	Pharmacy Name:
First Name	Primary Insurance
Middle Name:	Primary Policy Holder: - D.O.B - Sex (please circle): M or F
Address:	Primary Policy Holder Address:
City: State:	Secondary Insurance: - Member ID:
Zip:	Secondary Policy Holder: - D.O.B - Sex (please circle) M or F
Home Phone:	Secondary Policy Holder Address:
Work Phone:	**OTHER**
Mobile Phone:	
Patient Referred by:	
Sex:	Primary Care Provider:
Date of Birth:	Preferred Radiology Facility:
Patient Email:	Patient Spouse Name and Phone:
Patient Social:	Preferred Method of Contact:
Required by government mandate {although you may refuse]: Language:	**EMPLOYER/OCCUPTATION INFORMATION**
Race:	Employer/Occupation:
Ethnicity:	Address:
Marital Status:	Phone:
EMERGENCY CONTACT INFORMATION	**GUARANTOR INFORMATION**
Name:	Name:
Relationship:	Address:
Phone:	Relationship to Patient:
Mobile Phone: ( ) -	Date of Birth:
	Phone: ( ) -

Authorization for Treatment, Payment & Healthcare Operations.

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to the , its successors and assigns, or any individual it may designate for services provided. As part of this authorization, SQUARE CARE MEDICAL GROUP LLP will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law unless otherwise indicated. I understand that I have the right to request that services for which I have paid out-of-pocket, not be disclosed to my health plan. I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that I am responsible for such additional fees and I agree to pay such fees. It will be my personal responsibility to pay in full. I understand that I am financially responsible to SQUARE CARE MEDICAL GROUP LLP and any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plans filing limit for services rendered. I understand I am responsible for any late or no-show fees when applicable.

Signed: ______________________________ Date: ____________________