



Patient Number (office use only): \_\_\_\_\_

Referred By: \_\_\_\_\_

**PATIENT REGISTRATION SHEET**

**PATIENT INFORMATION**

Social Security #: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Suffix: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Which telephone number is best to reach you? Please check Home Work Cell

Sex (M/F): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_

Can we contact you via email? Yes No Email Address: \_\_\_\_\_

Usual Provider: \_\_\_\_\_ Referring Dr: \_\_\_\_\_ PCP: \_\_\_\_\_  
*if different from Usual Provider*

Marital Status (S/M/W/D): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**GUARANTOR INFORMATION**

Social Security #: \_\_\_\_\_ Sex (M/F): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Suffix: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_ Patient Relationship to Policy Holder: \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_ Policy Holder Phone: \_\_\_\_\_  
*if different from patient* *if different from patient*

Secondary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_ Patient Relationship to Policy Holder: \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_ Policy Holder Phone: \_\_\_\_\_  
*if different from patient* *if different from patient*

**ASSIGNMENT OF BENEFITS STATEMENT**

I request that payment of authorized insurance, Medicaid and Medicare benefits be made on my or my child's/children's behalf to ProHealth Physicians for services furnished to me by a ProHealth Physician. I authorize any holder of medical information about me or my child/children to release to the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) and its agents or my insurance company any information needed to determine the benefits payable including HIV/AIDS, substance abuse, and/or mental health information for related services. I further agree to make payment for any and all services not paid for by my health insurance plan. I have been provided an opportunity to review the ProHealth Notice of Privacy Practices.

X \_\_\_\_\_  
Signature of Beneficiary/Guarantor

\_\_\_\_\_  
Date