ProHealth PHYSICIANS

Patient Number (office use only): «PNumber»
Referred By: «RFName»

PATIENT REGISTRATION SHEET

PATIENT INFORMATION

Social Security #: _____ **Date of Birth:** _____

Last Name: _____ **First Name:** _____ **MI:** _____ **Suffix:** _____

Address: _____ **City:** _____ **Sex (M/F):** _____

_____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Can we contact you via email? ☐**Yes** ☐**No** **Email Address:** _____ *(not applicable if under 18yrs of age)*

Preferred method of communication: _____ **Legal Guardian Name:** _____

(Home Phone, Cell Phone, Work Phone, Mail, Print, Patient Portal)

Language: _____ **Race:** _____ **Ethnicity:** _____

(White, Black, Asian, Amr. Indian/Alaskan, Natv. Hawaiian/Oth. Islander) *(Hispanic, Latino, Non-Hispanic)*

Usual Provider: _____ **Referring Dr:** _____ **PCP:** _____

(if different from Usual Provider)

Marital Status (S/M/W/D): _____ **Employer:** _____

Emergency Contact: _____ **Relationship:** _____

Emergency Home Phone: _____ **Work:** _____ **Cell:** _____

GUARANTOR INFORMATION

Social Security #: _____ **Sex (M/F):** _____ **Date of Birth:** _____

Last Name: _____ **First Name:** _____ **MI:** _____ **Suffix:** _____

Address1: _____ **City:** _____

Address2: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Guarantor Email Address: _____

INSURANCE INFORMATION

Primary Insurance: _____ **Policy Holder:** _____

Cert No/Ins ID: _____ **Group No:** _____

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:** _____

Cert No/Ins ID: _____ **Group No:** _____

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 also authorize the release of any information between health care providers, including pharmacy information, for the purpose of providing care to me or my child to provide case management or care coordination services, or for payment of services or for eligibility determination. I 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 and have had the opportunity to have any questions answered.

X _____ _____
Signature of Beneficiary/Guarantor Date