



CONFIDENTIAL
PROGRESSIVE MEDICAL CARE, LLC
REGISTRATION INFORMATION

PLEASE PRINT

New Patient

Existing Patient

Existing Patient: Revise all information that has changed since your last visit

DATE ____/____/____ EMAIL ADDRESS _____

HOME PHONE: (____) ____-____

CELL PHONE: (____) ____-____

PATIENT'S NAME: _____, _____
LAST FIRST MI

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ RACE _____

SSN: ____ - ____ - ____ GENDER: M F BIRTH-DATE: ____/____/____
 Ethnicity _____ SINGLE MARRIED DIVORCED
 SEPARATED WIDOWED

Preferred Language _____

Patient Employed By : _____

Business Address: _____

Occupation: _____ Business Phone: (____) ____-____

Name of Spouse/Responsible Party (If Patient is minor): _____, _____
LAST FIRST MI

Spouse/Responsible Party Employed by: _____

Business Address: _____

Occupation: _____ Business Phone: (____) ____-____

RESPONSIBLE PARTY/SPOUSE SSN : ____ - ____ - ____

DO YOU HAVE MEDICAL INSURANCE ? NO YES **If Yes:**

NAME OF PRI. INS. : _____ ID #: _____ GRP #: _____

*SUBSCRIBER'S NAME: _____ *BIRTH DATE: ____/____/____

ADDRESS OF PRI. INS. : _____

NAME OF SEC. INS. : _____ ID #: _____ GRP #: _____

*SUBSCRIBER'S NAME: _____ *BIRTH DATE: ____/____/____

ADDRESS OF SEC. INS. : _____

***Required by HIPAA**

Pay my balance at the time of service Pay my balance upon receipt of first statement Make payment arrangement prior to rendering of services.

In case of emergency, who should be notified? _____ Relationship _____

Person authorized to receive PHI _____ Relationship _____

PHONE: (____) ____-____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____
(NAME OF INSURED) (NAME OF INSURANCE COMPANY)

to pay and hereby assign directly to _____ all benefits, if any, otherwise payable to
(PROVIDER'S NAME)

me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _____
(PROVIDER'S NAME)

will be credited to my account, in accordance with the above said assignment.

(AUTHORIZED SIGNATURE OF SUBSCRIBER)

(DATE)