GOOD MEDICINE REGISTRATION

PATIENT INFORMATION

Name_____Name Preferred_____

Physical Address_____Mailing Address_____

City/State/Zip_____City/State/Zip_____

Home Phone_____Business Phone_____Cell#_____

Birthdate_____Age_____Male/Female_____Marital Status_____

Social Security#_____EMAIL#_____

Referred By_____Family Physician_____

In case of emergency please notify_____Relation to Patient_____

Name_____Address_____Phone_____

PATIENT EMPLOYER INFORMATION

Present Employer_____Phone_____

Address_____City/State/Zip_____

RESPONSIBLE PARTY/INSURANCE GUARANTOR INFORMATION

Name_____Relationship to Patient_____

Mailing Address_____City/State/Zip_____

Home Phone_____Birthdate_____Social Security #_____

Employer_____Business Phone_____

INSURANCE INFORMATION

Primay Insurance_____ID#_____Group#_____

Subscriber Name_____Birthdate_____Relation to Patient_____

Secondary Insurance_____ID#_____Group#_____

Subscriber Name_____Birthdate_____Relation to Patient_____

Social Security# Primary Insured_____Social Security# 2ndary Insured_____

ASSIGNMENT & RELEASE/RECORD COPY

I hearby authorize my insurance benefits to be paid directly to Good Medicine. I am financially responsible for all services not covered by my insurance. I also authorize the physician to release any information required. There will be a $15.00 - $25.00 charge to copy records depending on the volume. We reserve the right to charge accordingly.

_____Date_____

Signature of Insured or Authorized Person