For office use only: Physician: _____ Consult Date: _____ Account #:_____

PATIENT REGISTRATION

Name: _____ DOB: _____/_____/_____
First MI Last

Street Address: _____ City/State/Zip: _____

Mailing Address: _____ City/State/Zip:_____
If different from street address

Home Phone: (_____)_____ Cell: (_____)_____ Work: (_____)_____

Employer: _____ Address: _____

SSN: _____-_____-_____ Sex: (please circle) M F Race: _____ Ethnicity: _____

Marital Status: _____ Spouse/Partner Name: _____

Spouse/Partner Employer: _____ Work: _____ Cell: _____

Emergency Contact: _____ Relationship: _____ Phone: _____
Not in same household

Primary Care Physician: _____ Referring Doctor: _____

Insurance: _____ Policy #: _____ Group: _____

***ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES (HIPPA):***
**By signing below, I acknowledge that I have been informed of the MCCM's Notice of Privacy Practices and a copy was made available to me.**

***AUTHORIZING PAYMENT:***
**I authorize the release of any medical information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to MCCM. I agree to be financially responsible for balances not covered by my insurance.**

***MEDICAL RECORDS:***
**I authorize MCCM to obtain my medical records from other healthcare providers for the purpose of providing medical care to me and I authorize MCCM to release my medical records to other healthcare providers for the same purpose.**

Patient Signature:_____ Date:_____
(or Personal Representative)