PATIENT REGISTRATION - GALEN MEDICAL GROUP

PATIENT INFORMATION:

NAME: ______________________________ ❑ MALE ❑ FEMALE

DATE OF BIRTH: ____________________ SOCIAL SECURITY #: ____________________

PRIMARY PHYSICIAN: ____________________ REFERRING PHYSICIAN: ____________________

PATIENT ADDRESS: ______________________________
Street / P.O. Box / Apt. No. *City / State / Zip Code* *County*

HOME PHONE: ____________________ WORK PHONE: ____________________

PATIENT EMPLOYER: ____________________ OCCUPATION: ____________________

EMPLOYER ADDRESS: ______________________________
Street / P.O. Box / Apt. No. *City / State / Zip Code*

SPOUSE INFORMATION:

NAME: ______________________________ DOB: ____________________

SOCIAL SECURITY #: ____________________

EMPLOYER: ____________________ WORK PHONE: ____________________

EMPLOYER ADDRESS: ______________________________
Street / P.O. Box / Apt. No. *City / State / Zip Code* *County*

EMERGENCY CONTACT INFORMATION:

NAME: ____________________ HOME PHONE: ____________ WORK PHONE: ____________

ADDRESS ______________________________
Street / P.O. Box / Apt. No. *City / State / Zip Code*

INSURANCE INFORMATION:

PLEASE PRESENT YOUR CURRENT INSURANCE CARD(S) TO OUR FRONT DESK SO THAT WE MAY MAKE COPIES AND FILE YOUR CLAIMS

PRIMARY INSURANCE NAME: ______________________________

SECONDARY INSURANCE NAME: ______________________________

ADVANCED DIRECTIVES:

It is the right of every adult citizen of Tennessee (18 years and over) to sign a Living Will, as well as a Durable Power of Attorney for Health Care that empowers an individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices you make in your Living Will will be binding on doctors, hospitals and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure your provider has a copy for your file.

AUTHORIZATION:

I authorize Galen Medical Group to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Health Care Financing Administration, Third Party Administrators, and/or Workers' Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize Galen Medical Group to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records.

I request that payment of Medicare, MediGap, Traveler's Railroad Retirement, Managed Care Organization, Third Party Administrators, Commercial, Worker's Compensation, Liability, and/or any other insurance benefits be made on my behalf to Galen medical Group for services furnished to me or on my behalf by that provider.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual writeoff agreement between Galen Medical Group and my third party payor. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

____________________ ____________ ____________________
Signature of Patient Date Signature of Responsible Party / Insured

***IMPORTANT*: PLEASE REFER TO BACK OF FORM AND COMPLETE ALL APPLICABLE SECTIONS.**

PLEASE COMPLETE THE FOLLOWING IF YOU ARE COVERED UNDER MEDICARE:

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in the correct billing of these services, please answer the following questions:

1. Are you employed?
   ❑ No Date of Retirement ______________________________
   ❑ Yes Please list employer information on front of form.
   Please complete health plan information on front of form.
2. Is your spouse employed?
   ❑ No Date of Retirement, if applicable ______________________________
   ❑ Yes Please list employer information on front of form.
   Please complete health plan information on front of form.

IF SERVICES ARE BEING PROVIDED TO YOUR DEPENDENT, PLEASE COMPLETE THE FOLLOWING:

MOTHER'S NAME: ______________________________

SSN: ______________________________ DATE OF BIRTH: ______________

ADDRESS: ______________________________

Street / P.O. Box / Apt. No. City / State / Zip Code County

EMPLOYER: ______________________________

ADDRESS: ______________________________

Street / P.O. Box / Apt. No. City / State / Zip Code County

HOME PHONE: ______________ WORK PHONE: ______________

FATHER'S NAME: ______________________________

SSN: ______________________________ DATE OF BIRTH: ______________

ADDRESS: ______________________________

Street / P.O. Box / Apt. No. City / State / Zip Code County

EMPLOYER: ______________________________

ADDRESS: ______________________________

Street / P.O. Box / Apt. No. City / State / Zip Code County

HOME PHONE: ______________ WORK PHONE: ______________

I hereby authorize Galen Medical Group, its physicians and staff, to render appropriate medical care to my dependent listed under patient information on the front of this form.

______________________________ ______________

Signature of Responsible Party Date

MISCELLANEOUS:

Are you eligible for coverage under the Veteran's Administration? ❑ Yes ❑ No

Are you eligible for coverage under Worker's Compensation? ❑ Yes ❑ No

Is your injury/illness due to an automobile accident? ❑ Yes ❑ No

If yes, please complete the following:

Name & address of auto insurance carrier:

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Name of Insured: ______________________________

Policy or ID#: ______________________________

Accident Date: ______________ Accident Location: ______________________________

THANK YOU FOR PROVIDING THIS NECESSARY INFORMATION.

Your assistance allows our Business Office to provide the best possible service in processing your claims.