

# IREDELL INTERNAL MEDICINE

## REGISTRATION FORM

(Please Print)

Today's Date:	Pt. Account#	PCP: Dr. Rhyne Dr. Ward Alice Roberts, FNP			
<b>PATIENT INFORMATION</b>					
Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	Parent Name if Minor:	Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:	Social Security no.:		Home phone no.: ( )		
P.O. box:	City:	State:	ZIP Code:		
Occupation:	Employer:	Employer phone no.: ( )			
Chose clinic because/referred to clinic by (Please check one box): <input type="checkbox"/> Dr. <input type="checkbox"/> Insurance plan <input type="checkbox"/> Hospital					
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other	Cell phone no.
Other family members seen here:					

<b>INSURANCE INFORMATION</b>					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date:	Address (if different):		Home phone no.: ( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:		Employer phone no.: ( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance <input type="checkbox"/> Medicare <input type="checkbox"/> BC&BS <input type="checkbox"/> Cigna <input type="checkbox"/> Aetna <input type="checkbox"/> United Health Care					
<input type="checkbox"/> Humana	<input type="checkbox"/> BC&BS State	<input type="checkbox"/> Partners BC&BS	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Other	
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

<b>IN CASE OF EMERGENCY</b>			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Iredell Internal Medicine, or insurance company to release any information required to process my claims and to release any information to other health care provider to whom I have been referred. I do voluntarily consent to such diagnostic procedures and care deemed necessary by the physician, his assistant or designated consultants.

*Patient/Guardian signature*

*Date*