



Patient Registration:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Ok to leave detailed voice messages? Yes  No  Ok to use email to enroll in patient portal? Yes  No

Gender: Female Male  
Marital Status: Married Single Widowed Divorced  
Race: Caucasian Hispanic Black/African American Asian American Indian/Alaskan  
Native Hawaiian/Other Other \_\_\_\_\_  
Ethnicity: Hispanic Origin Not of Hispanic Origin Refused by Patient  
Preferred Language: \_\_\_\_\_

Employment Status: Retired Disabled  
If Employed/Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_

Preferred Pharmacy: (Phone Number and Location)  
\_\_\_\_\_

Emergency Contact:  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

Who Referred you?  
\_\_\_\_\_

Primary: Insurance Company \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Secondary: Insurance Company \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

**Assignment of Benefits, Financial Responsibility and Release of Medical Information**

I request that payment of authorized Medicare benefits, or any other insurance benefits be made to either me or on my behalf to Phoenix Health Practitioners LLC for any services furnished to me by the Physician or Provider. I authorize any holder of medical information concerning me to be released to my insurance carrier or Health Care Financing, its agents; any information needed to determine these benefits or the benefits payable for related services. A photocopy of this authorization shall be considered effective and valid as the original.

I understand that I am financially responsible for all charges not covered by my insurance company and that all copays are due at the time of service.

**Patient or Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_