❑ New ❑ Update

LOC _____

F.C._____

MED REC # _____

DATE: _____ /_____ /_____
MO DAY YEAR

HATTIESBURG CLINIC

PATIENT REGISTRATION

— PATIENT INFORMATION —

PLEASE PRINT

E-MAIL ADDRESS _____

PATIENT'S NAME _____ **DATE OF BIRTH** _____ **AGE** _____ **SEX** ❑ **M** ❑ **F**

SOC. SECURITY #_____ **HOME PHONE** _____ **CELL PHONE** _____

ADDRESS _____ **CITY** _____ **ST**_____ **ZIP** _____

EMPLOYER _____ **EMPLOYER PHONE** _____

EMPLOYER ADDRESS _____ **CITY** _____ **ST**_____ **ZIP** _____

MARITAL STATUS_____ **ARE YOU RETIRED?** ❑ **YES** ❑ **NO** **ARE YOU DISABLED?** ❑ **YES** ❑ **NO**

IF APPLICABLE
RETIREMENT OR DISABLED DATE_____ **NAME OF EMPLOYER FROM WHERE YOU RETIRED OR BECAME DISABLED**_____

IS THIS VISIT RELATED TO BEING HURT ON THE JOB? ❑ **YES** ❑ **NO** **DATE OF ACCIDENT** _____

IS THIS VISIT RELATED TO A MOTOR VEHICLE ACCIDENT? ❑ **YES** ❑ **NO** **DATE OF ACCIDENT** _____

— IF STUDENT OR CHILD, PLEASE FURNISH US WITH YOUR PARENT'S INFORMATION —

MOTHER'S NAME _____ **SOC. SECURITY #** _____ **DATE OF BIRTH** _____

EMPLOYER _____ **PHONE** _____

FATHER'S NAME _____ **SOC. SECURITY #** _____ **DATE OF BIRTH** _____

EMPLOYER _____ **PHONE** _____

— SPOUSE INFORMATION —

SPOUSE'S NAME _____ **SPOUSE'S DATE OF BIRTH** _____ **SPOUSE'S SOC. SECURITY #** _____

EMPLOYER _____**EMPLOYER PHONE** _____

EMPLOYER ADDRESS _____ **CITY** _____ **ST**_____ **ZIP** _____

RETIREMENT DATE IF APPLICABLE _____

— OTHER THAN SPOUSE SOMEONE WE CAN CONTACT IN AN EMERGENCY —

NAME OF PERSON_____ **RELATIONSHIP TO PATIENT** _____

HOME PHONE_____ **OTHER PHONE** _____

— PERSON RESPONSIBLE FOR THE BILL AFTER INSURANCE PAYS —

NAME _____ **RELATIONSHIP TO PATIENT** _____

SOC. SECURITY #_____ **HOME PHONE**_____

ADDRESS _____ **CITY** _____ **ST**_____ **ZIP** _____

EMPLOYER _____ **EMPLOYER PHONE** _____

— REFERRAL INFORMATION —

REFERRING PHYSICIAN NAME _____

ADDRESS _____ **PHONE** _____

— PLEASE PROVIDE INSURANCE INFORMATION ON THE BACK OF THIS FORM —

NAME OF INSURANCE

EFFECTIVE DATE COPAY AMOUNT

SUBSCRIBER'S I.D. NUMBER (Include any letters)

SUBSCRIBER'S GROUP NUMBER OR NAME

SUBSCRIBER'S NAME (First, Middle, Last)

SUBSCRIBER ADDRESS IF DIFFERENT FROM PATIENT

SUBSCRIBER'S SOC. SEC# SUBSCRIBER'S DATE OF BIRTH

SUBSCRIBER'S RELATIONSHIP TO PATIENT

NAME OF INSURANCE

EFFECTIVE DATE COPAY AMOUNT

SUBSCRIBER'S I.D. NUMBER (Include any letters)

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SUBSCRIBER'S NAME (First, Middle, Last)

SUBSCRIBER ADDRESS IF DIFFERENT FROM PATIENT

SUBSCRIBER'S SOC. SEC# SUBSCRIBER'S DATE OF BIRTH

SUBSCRIBER'S RELATIONSHIP TO PATIENT

— PAYMENT POLICY —

NEW PATIENT PAYMENT POLICY

New patients to the Hattiesburg Clinic are required to pay on the day of services all charges, in full, for the initial visit and/or service.

Patient's or Authorized Signature: I hereby authorize release of medical information necessary to process this (these) claim(s) and permit the following to be used in place of the original document:

1) A photocopy or other facsimile reproduction of this authorization, or

2) Use of a computer to indicate that my signature is on file at the clinic.

I certify that information provided pertaining to my health insurance coverage for services rendered to myself by physicians associated with the clinic should be made payable to the Hattiesburg Clinic. I understand the clinic cannot accept responsibility for collecting my insurance claim or for negotiating a settlement on a disputed claim, and, that I am responsible for payment of my account with the limits of the above payment policy. I authorize the release of medical information to referring physicians and consulting physicians if necessary.

The signature below can be considered legal signature for purposes of appropriate identification as needed in the future.

PATIENT, PARENT OR LEGAL GUARDIAN SIGNATURE DATE

HATTIESBURG CLINIC EMPLOYEE EXT# DATE