

UNITY HEALTHCARE ALLIANCE

PHYSICIAN: _____

BEING SEEN TODAY

LOCATION: _____ DATE: _____

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ Driver's License # _____ State: _____
Name: _____
LAST FIRST MI SEX DATE OF BIRTH MM DD YY AGE S M D W O MARITAL STATUS
Address: _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE
Alt/Cell Phone: (_____) _____ Day Phone: (_____) _____ Email: _____

Race _____ Language _____ Ethnicity ☐ Hispanic/Latin ☐ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____

Emergency Contact: (Please indicate a friend or relative not living at the same address.)

NAME RELATIONSHIP (_____) EMERGENCY CONTACT #

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child _____ Other _____ Res. Party SS #: _____
SPECIFY

Name: _____
LAST FIRST MI SEX DATE OF BIRTH MM DD YY AGE S M D W O MARITAL STATUS
Address: _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____ (_____) _____ (_____) _____
WORK PHONE EXT

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____
_____/_____/____ Spouse's Work Phone: (_____) _____ (_____) Occupation: _____
DATE OF BIRTH EXT

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (_____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self _____ Spouse _____ Child _____ Other _____
(SPECIFY)

Employer's Name: _____
INSURED'S ID GROUP NAME AND/OR NUMBER

Address: _____
THC99P02 STREET CITY ST ZIP

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ /____ /____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self____ Spouse____ Child____ Other____
(SPECIFY)

Employer's Name: _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: _____
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: _____ Adj. _____

Address: _____ City: _____ State _____ Zip _____ Phone _____

Claim #: _____ DOI _____

What Employer: _____

ACCIDENT INFORMATION

Was this the result of an accident? ____Yes ____No Where did it occur? ____At Work ____Auto Accident ____Other

Date of Accident _____ Have you reported this injury to your employer? ____Yes ____No When _____

Describe accident briefly: _____

Do you have an attorney representing you? ____Yes ____No Who is the attorney? _____

REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____

Family Physician _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Unity Healthcare Alliance (UHA), and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

PATIENT SIGNATURE

DATE

WITNESS SIGNATURE

DATE