CIRCLE CARE Center

PATIENT REGISTRATION FORM

Please provide all requested information and sign form. **PLEASE PRINT.** Date_____

Last:_____ First:_____ Middle:_____

Preferred Name:_____ DOB:_____ SS#:_____

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

Phone: Cell: _____ Home:_____ Work: _____

Best number to call or leave message: (please check one) ☐ Cell ☐ Home ☐ Work

How did you hear about us? _____

Email: _____ Would you like access to the Patient Portal? _Y _N

Gender assigned at birth: _____ Current gender: _____

Reason for visit? _____ Is this a work injury? _____

Date of last physical: _____ Is this a "Welcome to Medicare" visit?_____

Primary Physician: _____ Phone: _____

Race: ___ Declined ____ Black or African American ____ Hispanic/Latino ___ American Indian or Alaska Native

___White ___ Native Hawaiian ___ Asian ___ White Hispanic/Latino ___ Pacific Islander ___ Other

Ethnic group: ____ Declined ____ Hispanic or Latino ____ Non Hispanic or Latino

Marital status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

Emergency Contact: _____ Phone: _____Relationship _____

Primary Insurance Information – <u>please give us your insurance card for us to copy</u>

Insurance Co. name: _____ ID#: _____

Group #:_____ Subscriber:_____ Subscriber DOB: _____

Relationship to patient: _____ Employer of Subscriber: _____

Secondary Insurance Information (if applicable)

Insurance Co. name: _____ ID#: _____

Group #:_____ Subscriber:_____ Subscriber DOB: _____

Relationship to patient: _____ Employer of Subscriber: _____

Allergies: _____

Drug Allergies: _____

Past Illnesses: _____ Date: _____

Past Illnesses: _____ Date: _____

Past surgeries: _____ Date: _____

Past surgeries: _____ Date: _____

Medication	Start date	Dosage

Financial Responsibility:
All copays must be paid at the time of service.
All deductibles and co-insurance are patient responsibility.
All statements for account balances are due upon receipt.
Any out of network or Insurance checks sent directly to you for payment must be endorsed and mailed to CIRCLE CARE Center with all supporting documents.
If your account is overdue 90 days, you agree to pay all reasonable fees incurred by CIRCLE CARE Center in attempting to collect any debt.
No-Shows (failing to show up for your appointment, or cancelling less than 24 hours before your appointment) are subject to a $50.00 fee.

Patient name: _____ Date: _____
(Please PRINT)

Patient Signature: _____

Legal Guardian: _____ Date: _____
(Please PRINT) (patients under 18)

Legal Guardian Signature: _____