

Patient Registration Information

Please print and complete all sections below

| | | | | | |
|-----------------------------------|--|---|------|--|------|
| Personal data | | Marital status: <input type="checkbox"/> married <input type="checkbox"/> single | | Gender: <input type="checkbox"/> male <input type="checkbox"/> female | |
| Name: _____ | | | | | |
| | | first | last | | m.i. |
| Date of Birth: ____ / ____ / ____ | | Drivers License # _____ | | | |
| Home phone (____) - _____ | | Work (____) - _____ | | Cell (____) - _____ | |
| Address: _____ | | | | | |
| | | address | city | state | zip |
| email: _____ | | | | | |

| | | | | | |
|--|--|--|------|---------------------|------|
| Responsible party (if not self) | | Relationship to patient <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other | | | |
| Name: _____ | | | | | |
| | | first | last | | m.i. |
| Date of Birth: ____ / ____ / ____ | | Drivers License # _____ | | | |
| Home phone (____) - _____ | | Work (____) - _____ | | Cell (____) - _____ | |
| Address: _____ | | | | | |
| | | address | city | state | zip |

| | | | | | |
|--|--|---------|----------------|-------|-----|
| Insurance data <i>Please present insurance card to receptionist</i> | | | | | |
| Insurance company: _____ | | | | | |
| Insurer's address: _____ | | | | | |
| | | address | city | state | zip |
| Insurer's phone #: (____) - _____ | | | | | |
| Policy #: _____ | | | Group #: _____ | | |
| Secondary insurance company name: _____ | | | | | |
| Insurer's address: _____ | | | | | |
| | | address | city | state | zip |
| Insurer's phone #: (____) - _____ | | | | | |

| | | | | | |
|---|--|--|--|--|--|
| Referred by: <input type="checkbox"/> relative <input type="checkbox"/> friend <input type="checkbox"/> newspaper <input type="checkbox"/> health fair <input type="checkbox"/> seminar <input type="checkbox"/> esagehealth.com | | | | | |
| <input type="checkbox"/> telephone directory <input type="checkbox"/> health insurance's website <input type="checkbox"/> other | | | | | |
| Other?: _____ | | | | | |

| | | | | | |
|---------------------------|--|---------------------|------|---------------------|------|
| Emergency Contact | | | | | |
| Name: _____ | | | | | |
| | | first | last | | m.i. |
| Home phone (____) - _____ | | Work (____) - _____ | | Cell (____) - _____ | |
| Address: _____ | | | | | |
| | | address | city | state | zip |

Assignment of Benefits

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Sage Health and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy or unaltered electronic copy of this agreement shall be as valid as the original.

Date: _____

Signature: _____