Internal Medicine Associates of Raleigh, PA

Patient Registration Review Worksheet

Patient Legal Name: **Chart:**

Mailing Address:

Birthdate: **Sex:** **Marital Status:** **Race:**

Home Phone: **Work Phone:** **Cell Phone:**

Pharmacy Name: _____ **Phone:** _____
Pharmacy Address: _____
Primary Insurance:
Name **Subscriber ID:**
Patient ID:
Benefits Assign: Y **Coverage Type:**
Release Info Date: **Notes:**

Secondary Insurance:
Name: **Subscriber ID:**
Patient ID:
Benefits Assign: **Coverage Type:**
Release Info Date: **Notes:**

Employer: Retired **OCCUPATION:** _____
Employer Address: **Telephone:**
Spouse Name: _____ **Date of Birth:** _____

Spouse Employer: _____ **Work Phone:** _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the physician to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers or others involved in processing and collection of this claim.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

I herby acknowledge that I have been informed about the Notice of Privacy Practices at Internal Medicine Associates of Raleigh, PA and have been given the opportunity to review it.

Signature: _____ Date: _____

EMERGENCY CONTACT INFORMATION: I authorize Internal Medicine Associates of Raleigh, PA to contact the Person listed below in case of emergency and/or regarding test results, health information.

Primary Contact Name: Relationship:
Home Phone #: Cell Phone #:

Secondary Contact Name: , Relationship:
Home Phone #: Cell Phone #:

Patient Signature: _____ Daytime Phone Number: _____

Language Preference: English/Other: _____ Hearing/Vision Barriers: _____

Date: _____