Southwest General Medical Group, Inc.

Patient Registration Form

Patient Acct #M: _____

PATIENT

Patient's Name: Last	**First *(legal)*:**	**Middle Initial:**	
Address:			
City:	State:	Zip:	
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
SSN#:	Birthdate:	Age:	
Home Phone #:	Cellular #:	Work #:	Ext:
Employer:			
Email Address:			
Can a message be left at your home? ☐ Yes ☐ No	Left on your answering machine? ☐ Yes ☐ No		

Race	**Ethnicity**	**Student:**
☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Alaskan Native-American Indian ☐ More than one race ☐ Unreported/Refused	☐ Hispanic ☐ Non Hispanic ☐ Unreported / Refused **Preferred Language :**	☐ Full Time ☐ Part Time ☐ Not Attending **How would you like to get notification of preventative reminders** ☐ US Mail ☐ Phone

Preferred Local Pharmacy:

Preferred Mail Order Pharmacy:

**** Please present your insurance card to the receptionist so that a copy can be made for our records****

INSURANCE

Primary Insurance:_____ ID# _____Group # _____

Subscriber's Name: _____ DOB _____ SSN _____

Relation to Patient ☐ Self ☐ Spouse ☐Father ☐ Mother ☐ Guardian ☐ Other
Employer Name: _____

Secondary Insurance _____ ID # _____Group # _____

Subscriber's Name: _____ DOB: _____ SSN: _____

Relation to Patient ☐ Self ☐ Spouse ☐Father ☐ Mother ☐ Guardian ☐ Other

FINANCE

Insured / Responsible Party (who is responsible for payment)

Name Last: First (legal) Middle Initial:

Address (if different than patient)

City:	State:	Zip:
SSN#:	Birth date:	
Phone #:	Relation to patient: ☐ Self ☐ Spouse ☐Father ☐ Mother ☐ Guardian ☐Other	

Emergency Contact:

Relationship to Patient: Home Phone: ( ) Cell Phone: ( )

Authorization for Treatment and Financial Disclosure

I authorize *SGMG, INC physicians* to release any information that may be necessary to comply with subpoenas, governmental regulations and laws. I also authorized this physician to release the following parties, any information they request from the physician: Medicare and/or insurer. For physician services provided to me, I assign to the physician all insurance or other payments made by other for my physician services. I request that payment of authorized benefits be made either to me or on my behalf to the above provider for services furnished by that physician. I authorize release to the indicated insurance carrier any medical information about me needed too determine these payments for related services.

I understand that I am responsible for payment of all bills for any services provided by an *SGMG physician*. If I do not provide the name of an insurance company or other party obligated to pay my bills, I will provide the physician with personal credit information and cooperate with physicians in establishing plan for payment of my physician services.

_____ _____

Patient or Responsible Party Signature Date