Queen Anne Medical Associates, P.L.L.C.
PATIENT REGISTRATION

Today's Date: _____ Referred by: _____

Patient Information:

Name: _____ DOB: _____
(last) (first) (mi)

Social Security number: _____ Sex: _____ Marital Status: S M D W Partnered

Address: _____

City: _____ State: ___ Zip Code: _____ E-mail: _____

Phone: Home: (___)_____ Work: (___)_____ Cell: (___)_____
*** Please put an asterisk* next to the phone number where we can leave a confidential message.

Employer: _____ Occupation: _____

Employer Address: _____

Spouse/Partner information:

Name: _____ Date of Birth: _____

Social Security Number: _____ Work phone: _____

Employer: _____ Occupation: _____

Insurance Information:

Primary Insurance : _____

Name of Insured: _____ Relation to Patient: _____

Insurance ID Number: _____ Group Number: _____

Insured's Employer: _____ Work Number: _____

Secondary Insurance: _____

Name of Insured: _____ Relationship to Patient: _____

Insurance ID Number: _____ Group Number: _____

Insured's Employer: _____ Work Number: _____

Emergency Contact: other than Spouse/Partner: _____

Phone: _____ Rel. to Patient: _____ Address: _____

Although services may be covered by insurance, I understand I am fully responsible for payment for care I receive. I understand an administrative service charge of 1% or $2.00 per month, whichever is greater, will be charged on all unpaid balances. I authorize payment of medical benefits to my physician for services rendered. I authorize the doctor or insurance company to release any information required for services rendered by this office.

Signed: _____ Date: _____