Seven Corners Medical Center

• Cardiology • Primary Care • Weight Loss

Registration Form

Part I – Patient Profile

How did you hear about us?

Last Name (in CAPS)

Gender

Male ☐ Female ☐

E-Mail Address

First Name(in CAPS) Middle Initial

Date of Birth of Patient (MM/DD/YYYY)

Mailing Address (Street Number and Name) Apt #

SSN of Patient

(City) (State) (Zip Code)

Employer of Patient Occupation

Evening Phone Number: _____-_____-________

Insurance Policy Holder/Name on Card

Daytime Phone Number: ____ - _____-________

Relationship to Patient

Emergency Contact Information

Name of Spouse or Next of Kin	Employer of Spouse or Next of Kin	Contact Phone Number

Drug Allergies

Part 2 – Insurance Company(s) Profile

Name of Primary Insurance Company and Address

Effective Date	Policy or ID Number	Group Number	Phone Number
			_____-_____-________

Name of Policy Holder/Name on Insurance Card

Date of Birth of Policy Holder (MM/DD/YYYY)

Name of Secondary Insurance Company and Address

Effective Date	Policy or ID Number	Group Number	Phone Number
			_____-_____-________

Name of Policy Holder/Name on Insurance Card

Date of Birth of Policy Holder (MM/DD/YYYY)

Part 3 – Policies and Payment

All professional services are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. Your insurance policy is a contract between your insurance company and you. We cannot accept responsibility for negotiating settlement of insurance claims. You are responsible for prompt payment of any bills due to us, from this service provided to you.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Seven Corners Medical Center to furnish information to the insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by the insurance.

I herewith attest that the information provided by me, in Part 1 and Part 2 of this form, is accurate.

_________________________________ _____________________________

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Name Signature Date