New Patient Registration Form

Date:_____Patient ID: _____

Patient Information Patient Full Name:_____

Home address:_____

City:_____ State:_____Zip: _____

Phone Number: Home:_____ Cell:_____Email: Primary: _____

Employment/ circle: employed full time student part time student disabled unemployed retired much

Employer or School:_____ Grade: _____

Marital Status/ circle: Single Married Divorced Divorce Pending Widowed Engaged Partnered Separated Date of Birth:___Gender/ circle: Male Female

Insurance Information

I am not using any insurance (self-pay)_____skip the insurance section

Primary Insurance:_____ Policy Number: _____Group: _____

Policy Holder/ circle: Patient Patient's Parent or Guardian Patient's Spouse If someone other than yourself is the insured party, please fill out the following section.

Name:_____Phone: _____

Home address:_____

City:_____State:_____Zip: _____

Date of Birth:_____Gender: Male Female Employer: _____

Secondary Insurance (if applicable):

Insurance:_____Policy Number: _____ Group: _____

Policy Holder: Patient Patient's Parent or Guardian Patient's Spouse If someone other than yourself is the insured party, please fill out the following section

Name:_____Phone: _____

Home address:_____

City:_____ State:_____Zip: _____

Date of Birth: _____Gender/circle: Male Female

Employer _____

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Assignment of Benefits l, the undersigned, assign to ProCare Wellness LLC all medical benefits, and authorize the release of this signature for all claim submission to my insurance company, including Medicare and/or Medicaid. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the facility and the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that health insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible or payment of all services, covered and non-covered. I understand that if I terminate my care and treatment, any fees or professional services rendered to me will be immediately due and payable.

Signature_____Date_____