

Dr. _____ Appt: _____

MEIER CLINICS PATIENT REGISTRATION

Acct# _____

PATIENT INFORMATION

1. Patient Name: _____
 (Last) (First) (Middle Initial) (Nickname)

2. Address: _____ Email: _____
 (City) (State) (Zip)

3. Home Phone: () _____ 4. Work Phone: () _____ Ext. #: _____

5. Soc.Sec #: _____ 6. Sex M F 7. Marital Status: S M D W 8. Birthdate: _____ Age: _____

9. Ethnicity: AmericanIndian/AlaskanNative ___ Asian ___ Black ___ Hispanic ___ White ___ Hawaiian/Pacific Islander ___ Other _____

10. Employer: _____ Occupation: _____

11. Student/School: _____ Full Time _____ Part Time _____

12. If dependent child, are custodial parents: Married _____ Separated _____ Divorced _____ Other _____

13. IN CASE OF EMERGENCY NOTIFY: Name _____ Relationship _____ Phone () _____

14. Primary Care Physician: _____
 (Name) (Address) (Phone)

FINANCIALLY RESPONSIBLE PARTY (GUARANTOR) INFORMATION

If same as patient, please complete only questions #1 & #6 of this section

1. Guarantor Name: _____ Birthdate: _____
 (Last) (First) (Middle Initial)

2. Guarantor Address: _____
 (City) (State) (Zip)

3. Guarantor Relationship to Patient (circle one): Spouse Mother Father Sibling Other Relative Friend Other

4. Home Phone: () _____ 5. Soc. Sec. #: _____ 6. Drivers License #: _____

7. Guarantor's Employer: _____ Work Phone () _____ Occupation _____

8. SPECIAL ARRANGEMENTS: _____

DO YOU HAVE INSURANCE*? _____ YES _____ NO (IF YES, PLEASE COMPLETE BELOW) **MEIER CONTRACTED TO BILL INS. YES NO**
 *Please note: Meier Clinics does not routinely bill insurance, unless the Meier Clinics provider is contracted with your insurance plan. If your Meier Clinics provider is not contracted with your insurance plan, it is still helpful to have this information on file for future reference.

1. **Primary** Insurance Co. Name: _____ Phone: () _____
 Insurance Co. Address: _____

2. Subscriber's Name: _____ 3. Relation to Pt: Self Spouse Parent Other
 Employer: _____ Wk Ph: () _____ Occupation: _____

4. Birthdate: _____ 5. Group ID #: _____ 6. Soc. Sec. #: _____

7. **Secondary** Insurance Co. Name: _____ Phone: () _____
 Insurance Co. Address: _____

8. Subscriber's Name: _____ 9. Relation to Pt: Self Spouse Parent Other
 Employer: _____ Wk Ph: () _____ Occupation: _____

10. Birthdate: _____ 11. Group ID #: _____ 12. Soc. Sec. #: _____

IF YOUR MEIER CLINICS PROVIDER IS CONTRACTED TO BILL YOUR INSURANCE PLAN, PLEASE SIGN THE FOLLOWING SECTION:

ASSIGNMENT OF BENEFITS: I hereby authorize and request my insurance to pay directly to Meier Clinics the amount due for services rendered to me or my dependents. RELEASE OF INFORMATION: I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered to me or my dependent.. This consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this release will be null and void six months after the final payment has been received on my account. This consent is subject to state and federal confidentiality requirements.

SIGNED: _____ PATIENT/GUARDIAN DATE: _____
 INSURED

GUARANTOR AGREEMENT: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Meier Clinics. If the provider is contracted with the insurance company, I will be responsible only for the co-pay, deductible, and non-covered services as determined by the insurance plan:

Guarantor Signature (Patient signature, if patient is guarantor) _____ Date _____