

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 \_\_\_\_\_