MEIER CLINICS® PATIENT REGISTRATION

Guarantor's Employer: Mork Phone: Occupation:	PATIENT INFORMATION							
Mailing Address:	Patient Name:							
Description Color		(Last)	(First)		(Middle Initial)	(Nicknam	e)	
Sucial Sactives Security 6 Sec Married Divorced Obter Districty Danates Data Districty Districty Data Districty Districty Data Districty	Mailing Address:	(Street/PO Box)	(Apt./Unit #)		(City)	(State)	(Zip)	
Social Security #: Social Married Divorced TWidowed Other	Home Phone:		Work Phone:		Ext. #:	Cell:		
Martial Status Single Married Divorced GWidowed Other	E-mail Address:							
Employer	Social Security #:		Sex:	□м □F	Birth date:		Age:	
Employer. Occupation: Student/School: Pluf-time Part-time Heperadem child, are custodial parents: Married OSeparated Divorced Ofther_ Relationship. In Case of Floorgency, notify: Name: Relationship. Address: Phone: Phone: Phone: Intitiol ONE only: I hereby consent for Meier Clinics® to contact my PCP listed below, as deemed necessary, regarding my treatment. This consent shall remain in force during my treatment at Meier Clinics® and for 90 days following my last visit unless I expressly revoke it in writing. I do not want my PCP Informed of my treatment at Meier Clinics® at this time. Frimary Care Physician: (Name) (Males Part Clinics® at this time. Frimary Care Physician: (Lau) (Frou (Males Easia) Phone: (Disco PRO Rox) (Disco PRO Rox) Guarantor Name: (Lau) (Frou (Males Easia) (City) (State) (Disco PRO Rox) Guarantor Mailing Address: (SteacPO Rox) (Moles PRO Rox) (Moles Easia) (Disco PRO Rox) (Moles PRO Rox) (Disco PRO Rox) (Moles PRO Rox) (Moles Easia) Guarantor Semployer: (SteacPO Rox) (Moles PRO Rox) (Moles PRO Rox) (Moles Easia) (City) (State) (Zip) Mork PRone: (Moles PRO Rox) (Moles PRO R	Marital Status: □Single	□Married □Divorced □	Widowed					
If dependent child, are custodial parents: "Married Separated Divorced Other	Ethnicity: American In	ndian/Alaskan Native	an □Black □Hispanio	c □White □	Hawaiian/Pacific Islander	□Other		
In Case of Emergency, notify: Name:	Employer:		Occupation:		Student/School:		□Full-time □Part-time	
Address:	If dependent child, are co	ustodial parents: Married	□Separated □Divorce	d Other				
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remain in force during my treatment at Meier Clinics® at this time. Primary Care Physician: (Name) (Abbess) (Phess) Claura	Address:				Phone	e:		
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Guarantor Name: Guarantor Mailing Address: Guarantor Mailing Address: Guarantor Relationship to Patient: □Spouse □Mother □Father □Sibling □Other Relative □ □Friend □Other. Home Phone: □ Cell Phone: □ Soc. Sec. #: Guarantor's Employer: □ Qocupation: □NSURANCE INFORNATION	Primary Care Physician:		(Address)			(Phone)		
Guarantor Mailing Address: GinearPO Boox CApat.Main #) (City) (State) (Zip)	FINANCIALLY RESPONSIBLE PARTY (GUARANTOR) INFORMATION							
Guarantor Mailing Address: (StreetPO Box) (Apt/Dinit #) (City) (Base) (Ztp)	Guarantor Name:					Birth date:		
Guarantor Relationship to Patient: Spouse Smother State Cle Phone: Soc. Sec. #: Guarantor's Employer: North Signature (Sures/PO Box) (Unit #) (City) (State) (Zip) NOTE: Meier Clinics® ONLY bills insurance if your provider is contracted with your insurance plan. Fill the following out ONLY if this is the case. Primary Insurance Co. Name: Phone: Occupation: Subscriber's Name: Relationship to Pt: Self Spouse Parent Other Employer: Member ID #: Soc. Sec. #:			(First)		(Middle Initial)			
Home Phone:	Guarantor Mailing Addr			(Apt./Unit #)	(City)		(State) (Zip)	
Guarantor's Employer:	Guarantor Relationship t	to Patient: Spouse Moth	er	□Other Rela	ative		r	
NSURANCE INFORMATION NOTE: Meier Clinics® ONLY bills insurance if your provider is contracted with your insurance plan. Fill the following out ONLY if this is the case.	Home Phone:		Cell Phone:		Soc. S	Sec. #:		
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NOTE: Meier Clinics® ONLY bills insurance if your provider is contracted with your insurance plan. Fill the following out ONLY if this is the case. Primary Insurance Co. Name:		(Sitecut O Box)				(State)	(Еф)	
Subscriber's Name:								
Employer:								
Birth date: Member ID #: Soc. Sec. #:	Subscriber's Name:			_ Relationship	to Pt: Self Spouse	□Parent □Other		
Subscriber's Name:	Employer:			Phone:		Occupation:		
Subscriber's Name:	Birth date:	Member l	D #:	(Group ID #:	Soc. Sec. #:		
Employer: Member ID #: Group ID #: Soc. Sec. #:	Secondary Insurance Co. Name:Phone:							
Birth date: Member ID #: Group ID #: Soc. Sec. #: 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 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. Patient's or Insured's Signature: Date:	Subscriber's Name:			Relationship	to Pt: Self Spouse	□Parent □Other		
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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. Patient's or Guardian's Signature: Date: 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, co-insurance, deductible, and non-covered services as determined by the insurance plan. Guarantor's Signature/Patient signature, if patient is guarantor: Date: Date:	Birth date:	Member l	D #:	(Group ID #:	Soc. Sec. #:		
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Comments:_