

PATIENT REGISTRATION FORM

Use this form if you are registering yourself



PATIENT INFORMATION

First Name	Last Name	<input type="checkbox"/> Male	<input type="checkbox"/> Female			
Address	City	State	Zip			
Date of Birth	Age	Social Security Number				
Living Status	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Other
Day Phone	Evening Phone	Cell Phone				
Email Address						
Employer Name	Employer Number					
Employer's Address	City	State	Zip			

Emergency Contacts

Name	Relationship	Phone
Name	Relationship	Phone
Whom May We Discuss Your Child's Medical Information With?		<input type="checkbox"/> Myself Only <input type="checkbox"/> Other

INSURANCE INFORMATION

Primary Insurance

Insured Name	DOB	SSN
Company Name	Policy / ID Number	
Address	Group Number	
City	State	Zip

Secondary Insurance

Insured Name	DOB	SSN
Company Name	Policy / ID Number	
Address	Group Number	
City	State	Zip

HEALTH INSURANCE CLAIMS SUBMISSION POLICY

Your insurance is a method for you to receive reimbursement for fees you have paid to our physicians for their services. Having insurance is not a substitute for payment. Many carriers have fixed allowances or percentages based on your contract with them, not with our office. If we participate with your insurance, we will accept the fees we have pre-negotiated with them. It is your responsibility to pay deductible, co-insurance, copays, and non-covered balances.

RELEASE AND ASSIGNMENT

I hereby authorize Lifeboat Medical Associates to apply for benefits on my behalf for services rendered each time my child(ren) presents for care. Further, I assign payments from my insurance carrier to Lifeboat Medical Associates for medical services rendered. I understand I am responsible for any amount non-covered by my insurance.

Signature

Date