CustomCare MD LLC Patient Registration Form (2006)
Please Print Information

Patient Name:_____Birthdate:_____

Home Address:_____

City:_____State_____Zip_____

Phone Numbers: Home ( )_____Cell ( )_____

Work ( )_____Patient's Social Security Number: _____

Marital Status: _____ Sex: M___ F___ Referred by:_____

Patient's Employer:_____

Person to Contact in Case of Emergency:_____

Relationship to Patient:_____Phone ( )_____

- Primary Insurance Company_____

ID (Policy) Number_____ Group Number_____
*If Policy Holder is other than patient, please complete the following:

Relationship to Patient:_____Policy Holder's Name:_____

Policy Holder's Address:_____

Policy Holder's Phone No. _____Social Security No._____

Policy Holder's Birthdate:_____

- Secondary Insurance Company_____

ID (Policy) No. _____Group No._____
*If Policy Holder is other than patient, please fill in the following:

Relationship to Patient:_____Policy Holder's Name:_____

Policy Holder Address:_____Phone:_____

Social Security Number:_____Policy Holder's Date of Birth:_____

Please complete both sides of form.

Due to Federal Regulations we need to know where and to whom we can release any of your medical information:

I authorize CustomCare MD LLC to release my Personal Health Information (PHI) to myself and or to my family in the following manner:
Release to (check all that apply)

☐ Answering Machine Phone Number(s):_____

☐ Fax Fax Number_____

☐ Spouse Spouse's Name_____

☐ Other Name and Relationship_____

☐ Mail ☐ Home ☐ Other Address_____

If patient is a minor or patient is under guardianship, please list responsible party information here:

Name:_____Relationship_____
Address:_____City:_____State_____Zip_____
Birthdate:_____Social Security Number:_____
Employer:_____Work Phone: ( )_____
Home Phone Number (if not the same as patient): ( )_____

I consent to treatment necessary for the care of the patient named on this document. I authorize CustomCare MD LLC to submit claims to my insurance carrier and release any information needed for the processing of claims related to medical services rendered. I allow for release of my **personal health information (PHI)** according to HIPAA law for treatment, payment and operations. I authorize assignment of benefits for physician and lab services to CustomCare MD LLC. A copy of this signature is as valid as the original. I understand that I am financially responsible for any service(s) not covered by my insurance carrier(s).

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

_____Date_____
PATIENT (OR LEGAL GUARDIAN) SIGNATURE

Please complete both sides of form.