DESERT PEAKS HEALTH CARE
PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Date:_____

Patient Name *(last / first / middle initial)*: _____ Birth Date: ____/____/_____

☐ Male ☐ Female ☐ Transgender Social Security # _____ Driver's License # _____ State _____

Mailing Address: _____ State ____ Zip _____ Cell Phone ( ) _____

Street Address: _____ State ____ Zip _____ Work Phone ( ) _____

Email Address: _____ Home Phone ( ) _____

Is this your first visit to Desert Peaks clinic? ☐ Yes ☐ No

Employer: _____

Employer Address, City, State, Zip:

_____

_____

Race: ☐American Indian or Alaska Native ☐Asian ☐Hispanic ☐Native Hawaiian ☐ Black or African American ☐White ☐ Other _____☐Unreported or Refused to Report

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Refused to Report

Language: ☐English ☐Spanish ☐Russian ☐Other _____

EMERGENCY CONTACTS:

I hereby give permission for the following individuals to be contacted in the event of an emergency:

Name:_____ Relationship: _____ Phone #: _____

Name:_____ Relationship: _____ Phone #: _____

INSURANCE INFORMATION: Do you have medical insurance? ☐ Yes ☐ No

Primary Insurance Company: _____ Phone #: ( ) _____

Subscriber Name: _____ *ID#* _____ *Group #* _____

Secondary Insurance Company: _____ Phone #: _____

Subscriber Name: _____ *ID#* _____ *Group #* _____

FINANCIAL AGREEMENT and RELEASE:

I, the undersigned, assign directly to DESERT PEAKS HELATH CARE, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Deductibles and co-pays are due at the time of service. If a self-pay party pays in full at the time of service, they are eligible for reduced fees. If it becomes necessary for third party collection, the undersigned agrees to pay for all costs and expenses including reasonable attorney fees. I understand there will be a $35 service charge on all returned checks. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signed _____ Date _____

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicate benefits be made either to me or on my behalf to Dr. _____ For any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signatures requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicate assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed _____ Date _____

NEW PATIENTS: *How did you hear about us?* ☐ Advertisement (*list source*) _____

☐ Family/Friend ☐ Physician Referral ☐ Provider Directory ☐ Internet ☐ Other _____