REGISTRATON FORM-PLEASE PRINT CLEARLY *Acct#*_____ *PCP:* ***H K Q S W***

EAST PARIS INTERNAL MEDICINE ASSOCIATES, P.C.

Name_____ Social Security #_____
Last First MI

Primary Address_____Apt. or PO Box_____

City_____ State_____ Zip_____ Marital Status: S__ M__ W__ D__ O__

Mobile ( )_____ Home ( )_____ Work ( )_____

Date of Birth:_____ Age____ Spouse/Parent Name_____

Secondary Address_____Apt. or PO Box_____

City_____ State_____Zip_____

Email address:_____

Patient Employed/Student at _____ Occupation_____

Gender Identity: M__ F__ Transgender___ Decline___

Ethnicity: Hispanic/Latino__ Non-Hispanic/Latino__ Other_____Decline____

Race_____ Preferred Language_____

IN CASE OF EMERGENCY NOTIFY: _____
Phone Number:( )_____

PLEASE PRESENT YOUR CURRENT INSURANCE CARD(S) AT EACH VISIT

Your insurance company and our office require you to pay any or all co-payments, deductibles, co-insurance and non-covered services at the time of service. We will bill all insurance companies, whether or not we participate, as a courtesy to you once your payment has been made. If we do not participate with your insurance company, you will be reimbursed for any covered benefits directly from your company. By signing this form, you authorize East Paris Internal Medicine Associates, P.C. to render necessary medical treatment, to release information to your insurance carrier for payment of services, and agree to pay for any and all non-covered services.

Patient/Legal Guardian Signature:_____ Date: _____

Medicare Authorization

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to East Paris Internal Medicine for any Services furnished me by one of its Providers. I authorize any holder of medical information about me to release to CMS and its agents any information necessary to determine these benefits or the benefits payable for related services. I understand my signature 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 CMS-1500 form, or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services based upon the charge determination of the Medicare carrier.

Beneficiary Signature_____ Date_____