

MAPLE MEDICAL,™LLP

Pulmonary, Critical Care, Internal Medicine, Endocrinology, Cardiology, Nephrology & Gastroenterology

PATIENT REGISTRATION FORM

PATIENT INFO	FIRST/MIDDLE/LAST NAME				
	HOME ADDRESS				
	EMAIL ADDRESS				
	HOME PHONE #		WORK PHONE #		MOBILE PHONE #
	LANGUAGE	DOB	SOCIAL SECURITY #		MARITAL STATUS
	PRIMARY CARE PHYSICIAN			EMPLOYER	
	EMERGENCY CONTACT			EMERGENCY PHONE #	
	PHARMACY NAME			PHARMACY ADDRESS & PHONE#	
	RESPONSIBLE	PERSON RESPONSIBLE FOR PAYMENT IF PATIENT IS UNDER AGE 18			
FIRST/MIDDLE/LAST NAME					
STREET ADDRESS					
HOME PHONE #		DOB		SOCIAL SECURITY #	
EMPLOYER NAME			EMPLOYER PHONE #		
INSURANCE INFO	PRIMARY INSURANCE				
	PRIMARY INSURANCE NAME			PRIMARY INSURANCE ADDRESS	
	SUBSCRIBER NAME			DOB	SEX
	SUBSCRIBER ID #		GROUP #		RELATION TO PATIENT
	SECONDARY INSURANCE				
	SECONDARY INSURANCE NAME			SECONDARY INSURANCE ADDRESS	
	SUBSCRIBER NAME			DOB	SUBSCRIBER NAME
	SUBSCRIBER ID #		GROUP #		SUBSCRIBER ID #
RELEASE	<p>I understand and accept that I will be financially responsible for all deductibles, co-payments, co-insurances, and non-covered charges as provided by my insurance plan. If I fail to cancel my appointment without at least 24 hours prior notice, a fee will be charged. If my insurance plan requires a valid referral to receive medical care, I understand that it is my responsibility to provide such referral. If my referral is determined to be invalid by my insurance carrier, I understand that I will be financially responsible for balances on my account including non-covered items. If my insurance plan is not accepted by this office or is of the indemnity type, I understand that I am financially responsible for all balances remaining after payment, if any, made by my insurance plan. I hereby authorize and assign directly to Maple Medical, LLP, all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the physician and/or their representative(s) to release any and all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.</p> <p>Patient Signature: _____ Date: _____</p>				