Silver Health CARE, PC

PATIENT REGISTRATION

PATIENT INFORMATION				Patient ID#
First Name:		Middle:	Last:	
DOB:	Age:	Sex:	SSN:	Marital Status:
Preferred Provider:		Primary Care Provider:		

Federal regulations now require that we collect the following demographic information.
Please check one of the options from each category.

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Decline to Answer
☐ Native Hawaiian/Pacific Islander ☐ White
☐ Black/African American ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Answer

Pharmacy Name: Pharmacy Phone #:
Pharmacy City: Mail Order Pharmacy:

CONTACT INFORMATION	Please check the box indicating how you would like us to communicate with you.	
Mailing Address:	City/State:	Zip:
Home Phone #:	Work Phone #:	Cell Phone #:
Email:	Employer:	
Emergency Contact:	Relationship:	Phone #:

BILLING INFORMATION	For minors or persons with legal guardians, indicate Financially Responsible Person.
Name:	Relationship:
Address:	Phone #:

Primary Insurance:
Policy #(include any dashes): Group:
Insurance Co Address:
Policyholder Info: Patient: ☐ Name:
DOB: SSN: Relationship:

Secondary Insurance:
Policy #(include any dashes): Group:
Insurance Co Address:
Policyholder Info: Patient: ☐ Name:
DOB: SSN: Relationship:

Permission is hereby granted to Silver Health CARE for such medical procedures, including the taking of photographs for treatment purposes only, as may be deemed necessary by my physician and/or his/her designee. I further consent to treatment by authorized employees or agents who are assigned to my care. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatment, examinations, or urgent care services. I acknowledge that I have been given SHC's Notice of Privacy Practices. I understand that if I have questions or complaints, I may contact SHC's HIPAA Privacy Officer. I understand that SHC will utilize tools to access digital information regarding proper care, including records obtained from other providers and sources.

I understand that I will be responsible for any co-insurance, deductible, or spend-down not covered by my insurance. If any balance is not paid when due, I understand that I will be responsible for the balance. I also understand that if the unpaid account is referred to an outside agency, I am responsible to pay all costs of collection including attorney fees. I hereby authorize the release of information to my insurance carrier or its intermediaries for all covered service rendered by Silver Health CARE.

Signature: Date: