BETH A. PURDY, MD, PLC **PATIENT REGISTRATION FORM**

Patient Name: _____ Date of Birth: _____ /_____ /_____ Sex ☐M ☐F
Last First

☐New Patient ☐Former Patient Social Security# _____-_____-_____

Home Phone# (_____)_____-_____ Cell# (_____) _____-_____

Address: _____ Marital Status ☐S ☐M ☐D ☐W

City: _____ State:_____ Zip: _____

Employer:_____ Work Telephone# (_____) _____-_____

Person to Notify in Case of Emergency: _____

Emergency Contact Relationship _____ Emergency Phone# (_____) _____-_____

Referring Physician (Physician who sent you to us): _____

Primary Care Physician:_____ Address: _____

INSURANCE INFORMATION

Primary Insurance Carrier:_____

ID#_____ SSN# _____ Group#/Name _____

Name of Policyholder: _____ Date of Birth: ___/___/_____ Sex ☐M ☐F

Employer: _____
Employer Address: _____

Relationship of Patient to Policyholder: ☐Self ☐Husband ☐Wife ☐Child ☐Other

Secondary Insurance Carrier: _____

ID# _____ SSN# _____ Group#/Name _____

Name of Policyholder: _____ Date of Birth: ___/ ___/ ____ Sex ☐M ☐F

Relationship of Patient to Policyholder: ☐Self ☐Husband ☐Wife ☐Child ☐Other

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Private insurance and any other health plan to Beth A. Purdy, MD, PLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure payment.

Notice of Privacy Practices for Protected Health Information and Acknowledgment of Notice Receipt

I acknowledge that I have received a copy of the HIPAA Notice of Pricy Practices implemented by this practice and understand that my protected health information may be used by the practice as described in the notice.

Furthermore, for the purposes of continuity of care, I specifically authorize Beth A. Purdy, MD, PLC to communicate my protected health care information with my primary care physician and/or referring physician(s) noted above. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

Signature of Patient or Responsible Party: _____ Date: ___/___/_____