ASSOCIATED PHYSICIANS OF SOUTHBURY

PATIENT REGISTRATION

DATE:_____

NAME:_____

STREET ADDRESS:_____

CITY, STATE, ZIP CODE:_____

PHONE: H_____,W _____, C_____

EMAIL ADDRESS:_____

DATE OF BIRTH:_____ MARITAL STATUS:_____

SOCIAL SECURITY NO:_____DRIVER'S LICENSE:_____

EMERGENCY CONTACT:_____PHONE:_____

NAME / PHONE OF PERSONS AUTHORIZED TO RECEIVE MY MEDICAL INFORMATION:

_____

DO YOU HAVE A LIVING WILL?(YES/NO) IF YES, PROVIDE A COPY FOR YOUR FILE

NAME AND PHONE OF PHARMACY:_____

INSURANCE INFORMATION: IF NOT INSURED CHECK HERE____

PRIMARY INSURANCE:_____SUBSCRIBER:_____

SUBSCRIBER'S DATE OF BIRTH:_____, EMPLOYER_____

SECONDARY INSURANCE _____, SUBSCRIBER:_____

SUBSCRIBER'S DATE OF BIRTH:_____

SIGNATURE AUTHORIZATION: I AUTHORIZE THIS PRACTICE TO RELEASE APPROPRIATE MEDICAL INFORMATION INCLUDING HIV AND PSYCHOLOGICAL REPORTS NECESSARY FOR CLAIM PROCESSING OR RECORDS FOR FINANCIAL BENEFIT:_____

PAYMENT AUTHORIZATION : I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO APOS FOR SERVICES RENDERED TO THEM IN PERSON OR UNDER DIRECT SUPERVISION. I

UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR COPAYS OR BALANCES NOT PAID. I WILL PAY MY COPAY AT MY VISIT. IF MY CHECK IS RETURNED, I WILL PAY BANK FEES. IF MY ACCOUNT GOES TO COLLECTION, I KNOW I WILL NEED TO FIND ANOTHER PHYSICIAN.

SIGNATURE:_____DATE:_____