

**Patient Registration Information**

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Sex:  Male  Female Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed Email address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Check one: Employed  Employer \_\_\_\_\_  Retired  Student  Other \_\_\_\_\_

**Primary Insurance Information**

Insurance Company: \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Date of Birth of Policy Holder: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Policy Holders SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to Policy Holder:  Child  Wife  Husband  Other \_\_\_\_\_

Insurance Number: \_\_\_\_\_ Group: \_\_\_\_\_

**Spouse/Parent/Guardian /Emergency Contact Information**

Relationship to Patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Please Read and Sign**

- I certify that the above information is true and correct to the best of my knowledge.
- I authorize the release of any medical information necessary to process this claim and also request payment of insurance benefits either to myself or to the party who accepts assignments.
- I authorize release of medical payment to MEDIQUICK
- I understand that should my account fall into arrears and be sent off to a collection agency or credit bureau, I will be responsible for any fees incurred.
- I understand that if my insurance company does not cover all of the professional service charges incurred, that I am responsible for any balance above insurance payment.
- Consent for treatment: I hereby consent the Provider to render medical evaluation treatment and the performance of diagnostic testing and procedures according to the Provider's discretion. **No guarantees will be made as to the results of examinations and or treatments.**
- I understand MediQuick may occasionally send a text and or email for review of services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_