POTOMAC ARTHRITIS & RHEUMATISM REGISTRATION FORM

Date _____

Patient Information:

Name _____ SSN (Optional) _____
Last First MI

Address _____ Home Phone _____ Cell Phone_____

City _____ State _____ Zip _____

Sex _____ Birthdate _____ Marital Status _____

Patient Employer/School _____ Occupation _____ Work Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Primary Insurance:

Person Responsible for Account _____ Relation to Patient _____

Responsible Party DOB _____ Responsible Party Phone Number _____
(if different from above)

Insurance Company _____ Group # _____ Subscriber # _____

Secondary Insurance:

Subscriber Name _____ Relation to Patient _____

DOB _____ Phone Number _____

Insurance Company _____ Group # _____ Subscriber # _____

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance with _____ and assign directly to *Dr. Madalene K. Greene*
(Name of Insurance Company (ies)
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named physician may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____ _____
Signature of patient, parent, guardian, or personal representative Date

_____ _____
Please *print* name of patient, parent, guardian, or personal representative Relationship to patient