



PATIENT REGISTRATION

2480 Berkshire Parkway, Suite B
Clive, Iowa 50325
(515) 987.4032
(515) 987.4195

Date: ____/____/____

Patient Name: _____
Last First MI

Street Address: _____ Home Phone: _____

City: _____ State _____ Zip _____ Work Phone: _____

Marital Status: (Circle) M S W D Mobile Phone: _____

Email Address: _____

Employer Name & Address: _____

Patient Date of Birth: _____ Sex (Circle) Male Female

Social Security # _____ Spouse's Name: _____

Previous Family Physician (if applicable) _____

Emergency Contact (Other than Spouse) _____

Relationship to Patient _____ Phone Number: _____

PATIENT INSURANCE

1. **PRIMARY** Insurance Company Name: _____

Address/City/State/Zip _____

Policy Holder (Insured's Name) _____

Policy Holder's Date of Birth _____

Policy Number _____ Group Number _____

What relationship is Policy Holder to the Patient? (Circle) Spouse Child Self
Other: _____

Is policy through Employer? If Yes, Employer's Name: _____

Effective Date of Policy: _____ Work Phone: _____

2. **SECONDARY** Insurance Company Name: _____

Address/City/State/Zip _____

Policy Holder (Insured's Name) _____

Policy Holder's Date of Birth _____

Policy Number _____ Group Number _____

What relationship is Policy Holder to the Patient? (Circle) Spouse Child Self
Other _____

Is policy through Employer? If Yes, Employer's Name: _____

Effective Date of Policy: _____ Work Phone: _____



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CONSENT TO TREAT: I authorize the healthcare providers of the office of **Preventative Health Clinic, Inc.** to administer treatment as deemed necessary for care of the patient named above. I certify that I am the parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

ASSIGNMENT OF BENEFITS: All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. The patient/parent/responsible party is responsible for any unpaid balances. Co-Payments will be made at the time of service. I request that payment of authorized Medicare, Medicaid, or other insurance company benefits be made to Preventative Health Clinic and/or its providers, for any services furnished to me by the office of **Preventative Health Clinic, Inc.**, healthcare provider. Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

Signature of Patient or Legal Representative

Date

If patient is under the age of 18:

Full Name of Parent or Legal Representative: _____

Relationship to Patient: _____ DOB: _____

Address if different than your own: _____

City _____ State _____ Zip _____ Day Phone _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

My signature below indicates that I have been given an opportunity to read this practice NOTICE OF PRIVACY PRACTICES and to have any questions answered before signing.

Signed: _____ Date _____

Print Name: _____

If signed by someone other than the patient, please indicate relationship to patient:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

For OFFICE USE ONLY: Employee Signature: _____ Date _____

Efforts to Obtain: _____

Reason patient refused to sign: _____

_____ Privacy Notice and Acknowledgment form mailed to the patient or legal representative at the addresses listed below:

Mailed to: _____

Address: _____

Reason: _____

Staff Signature

Date