



# 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: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Marital Status: (Circle) M S W D Sex: Male Female

Email Address: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Employer Name & Address: \_\_\_\_\_

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