**Richmond Internal Medicine**
PATIENT REGISTRATION

**PLEASE COMPLETE ALL SECTIONS**

| PATIENT NAME: | | | | DATE: | |
|---|---|---|---|---|---|
| First | Middle | Last | ☐ Male | ☐ Female | |
| Name you prefer to be called: | | How did you hear about us? | | | |
| Marital Status: | ☐ Single ☐ Married | ☐ Partnered ☐ Widowed | ☐ Separated | ☐ Divorced | |
| Address: | | | Apt # | | |
| City | State | | Zip | | |
| Home Phone: | Cell Phone: | | | | |
| Social Security #: | Birthdate: | | Age: | | |
| Employer: | | | Work Phone: | | |
| **Injury Information**: Date _______ | Where? ☐ Home or School | ☐ Work | ☐ Auto Accident | | |
| Nature or cause of injury: | | | | | |
| **Responsible Billing Party** / Relationship to Patient: | ☐ Self | ☐ Child | ☐ Parent | | |
| (give address and phone if different from above) | ☐ Spouse/Partner | | | | |
| Spouse or Partner's Name / Parent's Name (if patient is a minor): | | | | | |
| Spouse, Partner, or Parent's work phone: | | | | | |
| ***Whom shall we call in an emergency?*** (Please give name, address, area code and phone number of someone not living with you.) | | | | | |
| Relationship to you: | | | | | |
| **Primary** Medical Insurance Carrier: | | | Member #: | | |
| Subscriber Name and Date of Birth: | | | Group #: | | |
| Medicare Number: | | | | | |
| **Secondary** or Medicare Supplement Insurance Carrier: | | | Member #: | | |
| Subscriber Name and Date of Birth: | | | Group #: | | |

**Assignment and Release**: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for the balance due. I also authorize the doctor or insurance company to release information required for this claim. .

***If I have no insurance I agree to pay today for services provided to me by Richmond Internal Medicine.***

I, the patient / patient's legal representative, hereby grant permission to Richmond Internal Medicine physicians to perform such examinations and medical or therapeutic procedures as may be deemed professionally necessary for my / the patient's diagnosis and treatment.

I acknowledge receipt of Richmond Internal Medicine's Notice of Privacy Practices.

Signature: ______________________________________________ Date: ____________________