Registration Form



1. PATIENT INFORMATION

First name: _____ Last name: _____ Middle initial: _____

Birthdate: _____ Social Security #: _____ Sex: ☐ Male ☐ Female

Address: _____ Apt. #: _____ ☐ Other, please specify: _____

City: _____ State: _____ ZIP: _____ Cell phone: _____ Home phone: _____

Email: _____ Employer: _____

Language: ☐ English ☐ Spanish ☐ Other, please specify: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

2. RACE AND ETHNICITY

How do you identify? Select all that apply. You may choose not to answer.

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Hispanic or Latino ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander

☐ White ☐ Other, please specify: _____ ☐ Prefer not to answer

More detail about your race / ethnicity (optional): _____

3. EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

4. PHARMACIES

Primary pharmacy: _____ Phone: _____

Address: _____ Mail-away pharmacy: _____

5. CURRENT INSURANCE INFORMATION

Primary: _____ ID #: _____ Group #: _____

Secondary: _____ ID #: _____ Group #: _____

6. HOW DID YOU HEAR ABOUT CAREMEDICA?

☐ Referral ☐ Google Search ☐ Social Media

☐ Television Ad ☐ Friend / Family Member is a patient

☐ CareMedica website ☐ Other, please specify: _____

All professional services rendered by CareMedica is the responsibility of the patient set forth by their insurance carrier. If the patient feels to remit payments, disclose proper insurance information and/or does not list a CareMedica provider as their Primary Care Provider; patient will be turned over to collections. When an account is turned over to collections, the patient is responsible for any bills, interest and attorney fees incurred. **AUTHORIZATION OF PAYMENT:** I hereby authorize payment directly to the rendering Physician and/or CareMedica for services provided. **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize my rendering provider and/or CareMedica to release any information required from my examination and/or treatment to my insurance company for payment of services or to another provider for continuation of medical care. **MEDICARE STATEMENT (if applicable):** Claims will be submitted to Medicare for you by CareMedica. Medicare may not cover some services in which the patient may be responsible to pay if no other supplemental policy exists. Such identified services may include yearly physicals etc. In addition, you will be responsible to pay for your Annual Medicare deductible and coinsurance set forth by Medicare if you have chosen a supplemental policy to Medicare then it might cover your balance based on the coverage.

Signature: _____ Date: _____