Patient Registration Information

ARCH HEALTH Medical Group

HOW DID YOU HEAR ABOUT US? ☐ NEWSPAPER ☐ SOCIAL MEDIA/WEB SEARCH ☐ INSURANCE REFERRAL ☐ FAMILY/FRIEND

PATIENT INFORMATION

NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX: ☐M ☐F

BILLING ADDRESS	CITY	STATE	ZIP

PHYSICAL ADDRESS (If different than billing)	CITY	STATE	ZIP

HOME PHONE XXX-XXX-XXXX	WORK PHONE XXX-XXX-XXXX	CELL PHONE XXX-XXX-XXXX	EMAIL (example@test.com)

PREFERRED CONTACT METHOD (Required) ☐Home ☐Work ☐Cell ☐Email ☐Text	MARITAL STATUS	RACE	ETHNICITY

EMERGENCY CONTACT NAME	EMERGENCY PHONE XXX-XXX-XXXX

ADDRESS	PHONE#	OCCUPATION

PRIMARY EMPLOYER	SECONDARY EMPLOYER (If applicable)
ADDRESS	ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP
WORK PHONE / OCCUPATION	WORK PHONE / OCCUPATION

POLICY HOLDER/GUARANTOR (If different than patient)

NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX: ☐M ☐F

BILLING ADDRESS	CITY	STATE	ZIP

STREET ADDRESS (If different than billing)	CITY	STATE	ZIP

HOME PHONE XXX-XXX-XXXX	WORK PHONE XXX-XXX-XXXX	CELL PHONE XXX-XXX-XXXX	EMAIL

PREFERRED CONTACT METHOD (Required) ☐Home ☐Work ☐Cell ☐Email ☐Text	MARITAL STATUS	RACE	ETHNICITY

RELATIONSHIP TO PATIENT

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY #	
NAME OF POLICY HOLDER / BIRTH DATE	GROUP #	
RELATIONSHIP TO PATIENT	COPAY AMT. PCP $	SPECIALIST
ADDRESS OF INSURANCE COMPANY	DEDUCTIBLE AMT. SELF	DEDUCTIBLE AMT. FAMILY
CITY, STATE, ZIP	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY #	
NAME OF POLICY HOLDER / BIRTH DATE	GROUP #	
RELATIONSHIP TO PATIENT	COPAY AMTOUNT $	
ADDRESS OF INSURANCE COMPANY	DEDUCTIBLE AMTOUNT	
CITY, STATE, ZIP	EFFECTIVE DATE	EXPIRATION DATE

REFERRAL INFORMATION

NAME OF REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN

CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant Arch Health Medical Group to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. To the best of my knowledge, all of the information above is true and correct.

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.

ASSIGNMENT OF BENEFITS: I thereby assign all benefits payable by my insurance company to Arch Health Medical Group.

Patient / Guardian Signature _____ Date _____ Relationship to Patient _____