Bluegrass Internal Medicine

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REGISTRATION FORM

PATIENT NAME: _____
First Middle Last

ADDRESS: _____

City/State/Zip_____

SS#_____**DATE OF BIRTH**_____**Age**____
Month Day Year

Home Telephone: _____ **Cell Phone:** _____

Alternate Phone: _____ **Name at Alternate #:**_____

Employer:_____ **Work Phone:** _____

Address of Employer:_____ _____ _____
Street City State Zip

Marital Status: _____ **Sex (Please Circle One) Male Female**

What Physician are you seeing today?_____

In case of an Emergency, who should be notified? _____ _____
Name Phone

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize my signature on all insurance and Medicare claim forms, electronic or paper form, at the office of Bluegrass Internal Medicine for payment directly to the physician for service rendered to me/patient. I authorize this office to make and send copies of medical records, electronic or paper, that may be needed to file my insurance. **I understand, I, (the patient) am responsible for charges incurred regardless of whether my insurance pays or not.** I, the patient, also understand that I am responsible for any attorney fees and court costs incurred in collecting any unpaid balances for services. I, the patient also understand that I am responsible for any attorney fees and court costs incurred in collecting any unpaid balances for services received. I agree that this statement applies to all current and future claims.

Signature: _____ **Date:**_____

COPAYS ARE DUE AT DATE OF VISIT