

Please call (623)374-7774 if you need assistance filling out this form.

REGISTRATION FORM

(Please Print)

Today's Date:			Community Name:		
PATIENT INFORMATION					
Last name:	First name:	M.I.	<input type="checkbox"/> Assisted <input type="checkbox"/> Independent <input type="checkbox"/> Memory Care	Marital status:	
				Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date:	Age:
					Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			City:	State:	Zip Code:
Apartment no.:	Social Security no.:		Home phone no.:		
Chose MD24 because/referred to MD24 by (Please check):			<input type="checkbox"/> Dr.	<input type="checkbox"/> Community	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Other			

INSURANCE INFORMATION					
Please indicate primary insurance	<input type="checkbox"/> Medicare	<input type="checkbox"/> Cigna PPO	<input type="checkbox"/> BCBS of AZ	<input type="checkbox"/> SecureHorizons	<input type="checkbox"/> APIPA
<input type="checkbox"/> Humana PPO	<input type="checkbox"/> Health Net	<input type="checkbox"/> Aetna	<input type="checkbox"/> UnitedHealthCare	<input type="checkbox"/> PacifiCare	
<input type="checkbox"/> SCAN	<input type="checkbox"/> Evercare	<input type="checkbox"/> Other			
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: \$
Name of secondary insurance (if applicable):	Subscriber's name:		Policy no.:		
Name of preferred Pharmacy:			Phone/Fax no.:		
Current Primary Physician Name:			Phone/Fax no.:		
<input type="checkbox"/> Check if patient would like MD24 to become his/her Primary Physician.					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
<p>The above information is true to the best of my knowledge. I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize the payment of benefits be made to the provider in my behalf or to myself. I understand that I am fully responsible for all charges incurred, regardless of my insurance status for professional services rendered.</p> <p>I have been given a copy of the "Notice of Privacy Practices" by MD24, Inc. I understand that in order to treat any patient, MD24, Inc., will have to gather, store and use my medical record, and that record is subject to special federal legal protections. I give my consent to MD24, Inc. to gather, store and use my medical record for treatment, billing and health care operational purposes.</p>			
X			
<i>Patient/Power of Attorney signature</i>		<i>Date</i>	