# MOUNT VERNON PRIMARY CARE ASSOCIATES, PLLC

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## PATIENT REGISTRATION – *Please Print Clearly*

| PATIENT NAME Last M.I. First | | | | DATE OF BIRTH / / | AGE |
|---|---|---|---|---|---|
| HOME ADDRESS APT # | | CITY | | STATE | ZIP |
| SS# - - | SEX | MARITAL STATUS ❑ S ❑ M ❑ D ❑ W | | HOME PHONE# ( ) | |
| EMPLOYER *(or previous employer, if retired)* ❑ SELF ❑ MILITARY ❑ P/T ❑ F/T ❑ RET | | STUDENT STATUS ❑ P/T ❑ F/T | | WORK PHONE# ( ) | |
| EMPLOYER ADDRESS | | CITY | | STATE | ZIP |
| SPOUSE / PARENT / CONTACT NAME | | RELATIONSHIP TO PATIENT | | SPOUSE / PARENT / CONTACT DAYTIME PHONE # ( ) | |
| SPOUSE / PARENT / CONTACT ADDRESS APT # | | CITY | | STATE | ZIP |

## RESPONSIBLE PARTY INFORMATION – *Person Responsible for Bill* ❑ *Same as patient*

| NAME Last M.I. First | | DATE OF BIRTH / / | SS# - - | SEX |
|---|---|---|---|---|
| RELATIONSHIP TO PATIENT | HOME PHONE # ( ) | WORK PHONE # ( ) | EMPLOYER | |
| HOME ADDRESS APT # | CITY | STATE | ZIP | |

## PRIMARY INSURANCE INFORMATION

| NAME OF INSURANCE COMPANY | | COPAY AMT $ | EFFECTIVE DATE |
|---|---|---|---|
| INSURANCE ADDRESS | CITY | STATE | ZIP |
| GROUP # | POLICY # | | |

SUBSCRIBER INFORMATION *( if other, please state relationship and complete following information)*
❑ same as patient ❑ same as responsible party ❑ other: ____________________

| NAME Last M.I. First | | DATE OF BIRTH / / | SS# - - | SEX |
|---|---|---|---|---|
| EMPLOYER | HOME PHONE # ( ) | WORK PHONE # ( ) | | |

## SECONDARY INSURANCE INFORMATION

| NAME OF INSURANCE COMPANY | | COPAY AMT $ | EFFECTIVE DATE |
|---|---|---|---|
| INSURANCE ADDRESS | CITY | STATE | ZIP |
| GROUP # | POLICY # | | |

SUBSCRIBER INFORMATION *( if other, please state relationship and complete following information)*
❑ same as patient ❑ same as responsible party ❑ other: ____________________

| NAME Last M.I. First | | DATE OF BIRTH / / | SS# - - | SEX |
|---|---|---|---|---|
| EMPLOYER | HOME PHONE # ( ) | WORK PHONE # ( ) | | |

## PATIENT AUTHORIZATION

I, ____________________, hereby authorize MVPCA to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made directly to the above named practice.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information including medical information for this or any other related claim. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. ❑ **Do you have Advanced Directives?** ❑ **Would you like information on Advanced Directives?**

_______________________________________ *Signature*

_______________________________ *Date*

REVISED 01/04/08