

**HELDFOND MEDICAL GROUP**  
Patient Registration Form

Account #	Physician	<input type="checkbox"/> New Patient	<input type="checkbox"/> Update	<input type="checkbox"/> Cash	<input type="checkbox"/> PPO
Race:		Ethnicity:		Language Pref:	
Patient Name		SS #		DOB	
Address		City		State & Zip	
Mailing/Billing Address		City		State & Zip	
Employer					
Employer Address			City		State & Zip
Spouses/Partner Name					SS#
<b>To respect your privacy, please tell us which of the following we should use to communicate with you regarding appointment reminders, lab results, etc. Only check the contact information in which you want us to use.</b>					
<input type="checkbox"/> Home: _____		<input type="checkbox"/> Cell: _____			
<input type="checkbox"/> Work: _____		<input type="checkbox"/> E-mail: _____			
<b>Please provide your e-mail address for our secure Patient Portal. E-mail: _____</b> The Patient Portal is a way for you to communicate with our office and request appointment times on-line.					
Primary Physician					Phone
Address			City		State & Zip
Referred By	Address		City		State & Zip
Name of Insured			DOB		SS #
Drug Allergies					<input type="checkbox"/> N/A
<b>PHARMACY INFORMATION</b>					
Pharmacy Name			Phone		Fax
Address			City		State & Zip
<b>EMERGENCY CONTACT</b>					
Name/Relationship (i.e.: partner, family, friend)					Emergency Phone
<b>PERSON RESPONSIBLE FOR YOUR BILL</b>					
Name					Phone:
Address			City		State & Zip
<b>I understand that I am responsible for charges, deductibles and appropriate co-payments at the time of service unless other arrangements have been made with the billing office.</b> <b>I authorize payment of medical benefits to be made directly to the physician for services rendered and I am responsible for any payment and non-covered service.</b>					
Signature					Date
<b>AUTHORIZATION TO RELEASE INFORMATION</b>					
I hereby authorize the Physician to release any information necessary acquired in the course of my treatment to process insurance claims. I understand by not supplying my complete insurance information, I will be responsible for my account balance.					
Signature					Date