GUIDINGSTAR tampa

Together, Building a Culture of Life!

PATIENT REGISTRATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ City_____ State ____ Zip _____

Cell Phone _____ Work Phone _____

SS# _____ Date of Birth _____ Sex ____ Marital Status _____

Employers Name _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

Primary Insurance

Insurance Name _____ Policy # _____ Phone _____

Name of Insured _____ Relationship _____

SS# _____ Date of Birth _____

Employers Name _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

Secondary Insurance

Insurance Name _____ Policy # _____ Phone _____

Name of Insured _____ Relationship _____

SS# _____ Date of Birth _____

Employers Name _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

PCP Name _____ Phone _____

Emergency Contact _____ Phone _____

Preferred Pharmacy/Location _____ Phone _____

Preferred Lab/Location _____ Phone _____

I hereby authorize providers of Guiding Star Tampa to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the medical practitioner to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency.

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the clinic and I am financially responsible for non covered services. I also authorize the clinic to release any information required in the processing of this claim and all future claims.

Signature of Patient / Authorized Person _____ Date _____