PATIENT REGISTRATION
Updated Yearly

PATIENT INFORMATION:

NAME: ____________________ ADDRESS: ____________________

CITY: ____________________ STATE: ________ ZIP: ____________

DOB: __________ SS #: ______________ SEX: M F HOME #: ____________

E-MAIL ADDRESS: ______________________________ Cell #: ______________
(By providing your email address you are consenting to Liberty Medical Center staff to use it to send you lab results, and other correspondence regarding your medical care, etc. and realize that emails are not 100% secure.)

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

PATIENT EMPLOYMENT INFORMATION: **INSURANCE INFORMATION:**

EMPLOYER: ____________________ **POLICY#** __________ **GROUP#** ________

ADDRESS: ____________________ **POLICY HOLDER**: ______________

CITY: ______________ STATE: ________ ZIP: __________ WORK #: ____________

PERSON RESPONSIBLE FOR BILL:

NAME: ____________________ ADDRESS: ____________________

CITY: ____________________ STATE: ________ ZIP: ____________

DOB: __________ Social Security #: ____________ SEX: M F HOME #: ____________

WORK #: ______________ RELATIONSHIP TO PATIENT: ______________

RESPONSIBLE PARTY EMPLOYER: ______________ EMPLOYER PHONE #: ______________

EMERGENCY CONTACT:

NAME: ____________________ ADDRESS: ____________________

CITY: ____________________ STATE: ________ ZIP: ____________

HOME #: ____________ WORK #: __________ RELATIONSHIP TO PATIENT: ____________

INSURANCE/CREDIT CARD INFORMATION:
Insurance card/credit cards are requested by this office to keep such information up-to-date to properly charge your account/insurance. If at any time your insurance or credit card information changes, please let us know so we have the correct information. You authorize your credit card to be charged for any outstanding balance, any no-show fees, co-payments (including those to reserve future appointments) or any other charges that you owe but have not paid. You authorize payment of medical benefits to be made directly to Liberty Medical Center.
ALL CO-PAYS AND INSURANCE DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.

CREDIT CARD: VISA MASTERCARD DISCOVER AMERICAN EXPRESS OTHER

Credit Card #: ____________________ **Expiration Date:** ______________

Signed: ____________________ Relationship to Patient (If Signed By Guardian): ________
Date: ________

Witness: ____________________ Date: ______________