

Patient Registration Form

Medical Specialists of Fairfield

FOR OFFICE USE ONLY

DATE _____

PATIENT # _____

PATIENT INFORMATION *(please print)*

First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____ Social Sec. # _____ Sex M F

Marital Status S M D W Other _____

Referring Doctor _____ Primary Care Doctor _____

Home Address _____

City _____ State _____ Zip Code _____

Billing Address (if different) _____

Home Phone _____ Cell Phone _____

Employer _____ Employer Phone _____

Employer Address _____

City _____ State _____ Zip Code _____

Work Phone _____

Emergency contact _____ Relationship _____ Phone _____

Do you have a Living Will? Yes No

Do you have an Advanced Care Plan? Yes No If yes, name _____

Are you seeing a doctor because of an accident or injury? Yes No

If yes, date: _____ Description of Accident _____

BILLING INFORMATION

Responsible Party (if insurance will not pay) _____

I authorize Medical Specialists of Fairfield, LLC to release my medical information as necessary concerning my medical treatment. I hereby request that Medical Specialists of Fairfield submit medical claims on my behalf directly to my insurance carrier and that my insurance carrier pay medical benefits directly to Medical Specialists of Fairfield, LLC.

Signature (Patient or Parent of Minor): _____ Date: _____

INSURANCE INFORMATION

Primary Insurance _____

Policy Holder Name _____ DOB _____ SS# _____

Policy I.D. _____ Group # _____

Patient Relation to Policy Holder: Self Spouse Child _____

Policy Effective Date: _____ Co-pay Amount _____

Secondary Insurance _____

Policy Holder Name _____ DOB _____ SS# _____

Policy I.D. _____ Group # _____

Patient Relation to Policy Holder: Self Spouse Child _____

Policy Effective Date: _____ Co-pay Amount _____