NEW PATIENT REGISTRATION FORM

Patient Name (Please Print): _____

Mailing Address: _____

Street Address: _____

Sex: _____Male _____Female **Birth Date**: _____

Home Phone: _____ **Cell Phone**: _____
Email: _____@_____

Emergency Contact: _____ Relationship:_____

Home Phone: _____ **Work Phone:** _____

Preferred Pharmacy:_____

Responsible/Insured Party Information:

Name: _____ **Relationship**: _____

Address: _____

Home Phone: (__)_____ **Work Phone**: (__)_____

Birth Date:_____ **Employer**:_____

Policy Number:_____ **Group Number:**_____

Assignment of Benefits and Authorization to Release Medical Information

I request that payment of authorized benefits Medicare, Medicaid, and/or any Insurance Carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release it to the division of Family Services, the Health Care Financing Administration, listed insurer (s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services.

Signature:_____ **Date:**_____

I have been made aware of the Sliding Fee Discount Program offered by Central Ozarks Medical and Dental Centers. I would like to ***Apply***_____ *or* ***Not Apply***____. *If you choose apply, forms to do so will be provided by Reception Staff. If you have not been informed of this program please ask Reception Staff for details.*

If you are enrolled in Medicare, please provide HIC number and sign below

I request payment of authorized Medical benefits be made to Central Ozarks Medical Center, and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

HIC Number: _____

Signature:_____ **Date:**_____