

## PATIENT REGISTRATION FORM

❖ **Patient Information:**

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F Marital Status: S D M W

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Provider usually seen here at CMG: \_\_\_\_\_

Primary Care Provider (if other than a CMG provider): \_\_\_\_\_

**Other Patient Data Requested (Optional):** Please check this box if you do not wish to answer

Race :  Amer. Indian or Alaska Native /  Asian /  Black or African American /  Hawaiian or Other Pacific Islander /  White

Ethnicity:  Hispanic/Latino or Other

❖ **Responsible Party** (If Patient is a minor 0-17yrs of age): or  **Check here if same as above** (patient is 18 or over)

Parent/Guardian Name \_\_\_\_\_ Relation to patient \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

A copy of your insurance card and photo ID must be presented at each visit in order for us to bill your insurance company. If you do not present your card and eligibility can not be confirmed you will be expected to pay for your visit in full. You can submit the claim to your insurance company for reimbursement. If you do not have insurance, payment must be made in full at the time of service. If you have an existing balance you will be expected to pay the balance in full or set up a payment plan. We require a minimum of 20% a month on balances over 30 days old.

The undersigned signature affirms that the diagnosis treatment plan(s) and patient instructions were given and requests that payment of authorized benefits be made to Clarkston Medical Group, P.C., Clarkston Urgent Care, PLC and/or Associated Radiologists of Clarkston, PLC for any services furnished to the patient by Clarkston Medical Group, P.C., Clarkston Urgent Care, PLC and/or Associated Radiologists of Clarkston, PLC. I authorize any holder of medical information about the patient to release to my insurance company and it's agents any information needed to determine benefits or the benefits payable for related services. Further, the undersigned signature below also acknowledges my agreement to pay all medical services rendered at any of our facilities not covered by insurance.

Authorized Responsible Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Manager # (Office use only): \_\_\_\_\_

***\*Turn Over for Insurance Information\****

**CLARKSTON MEDICAL GROUP, P.C.**  
5701 Bow Pointe Dr., Suite 100  
Clarkston, MI 48346

**ASSOCIATED RADIOLOGISTS OF CLARKSTON, PLC**  
5701 Bow Pointe Dr., Suite 110, Clarkston, MI 48346  
7210 North Main Street, Suite 211, Clarkston, MI 48346

**CLARKSTON URGENT CARE, PLC**  
5701 Bow Pointe Dr., Suite 120  
Clarkston, MI 48346

## INSURANCE INFORMATION

### First Insurance:

❖ **Insurance Policy Holder (Subscriber)** *A photo ID & Insurance card must be presented at each visit*

Subscribers Name: \_\_\_\_\_ Patient Relation to Subscriber \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F

Insurance Carrier \_\_\_\_\_ Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber's Place of Employment: \_\_\_\_\_

### Second Insurance:

❖ **Insurance Policy Holder (Subscriber)** *A photo ID & Insurance card must be presented at each visit*

Subscribers Name: \_\_\_\_\_ Patient Relation to Subscriber \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F

Insurance Carrier \_\_\_\_\_ Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber's Place of Employment: \_\_\_\_\_

### Third Insurance:

❖ **Insurance Policy Holder (Subscriber)** *A photo ID & Insurance card must be presented at each visit*

Subscribers Name: \_\_\_\_\_ Patient Relation to Subscriber \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F

Insurance Carrier \_\_\_\_\_ Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber's Place of Employment: \_\_\_\_\_

❖ **Whom may we thank for referring you to our practice? Please circle all that apply:**

Clarkston Medical Group Website

CMG Urgent Care

Newspaper Article

Advertisement on Radio: \_\_\_\_\_

Advertisement in: \_\_\_\_\_

Insurance Company \_\_\_\_\_

Friend \_\_\_\_\_

Physician \_\_\_\_\_

Other \_\_\_\_\_