Primary Care, PLLC | Primary Care GYN, PLLC | St. Croix Diagnostics, LLC

Patient / Client Registration Form

Patient Name: _____ Sex: _____

Date of Birth: mm/dd/yy: _____ Social Security #: _____

MAILING ADDRESS (Patient's &/or Responsible Party's): _____

City: _____ State: _____ Zip Code: _____

E-Mail Address: _____

Participation in Patient Portal: Yes_____ No_____ (Non Participants will receive mail via USPS at address provided)

Home Tel: ( ) _____ Cell Tel: ( ) _____ Work Tel: ( ) _____

Responsible Party Name: _____ _____ Tel: ( ) _____

Emergency Contact Name: _____ Tel: ( ) _____

Relationship: _____

Name of Current Employer: _____ Occupation: _____

Insurance: _____ Name of Insured: _____

Insurance Policy #: _____ Group Number: _____

Social Security Number of Insured: _____ Date of Birth of Insured: _____

Please READ and INITIAL the following information:

- I have received a Notice of Privacy written in plain language. This notice provides in detail the uses and disclosures of my Protected Health Information that may be made by this practice, my Individual Rights and the practice's Legal Duties with respect to my Protected Health Information. _____
- I authorize the release of any information required to process any insurance claim or any report required by municipality or governmental agency. _____
- I authorize my insurance benefits to be paid directly to the provider. _____
- I understand that I am solely responsible for any error or omissions that I may have made in the completion of this form. _____
- I understand that it is my responsibility to inform my doctor if I have any changes with my health Status. _____
- I agree that I am responsible for all charges incurred for services provided to me or to whom I am responsible for, including those not covered by my insurance company, late fees and collection costs. _____
- To the best of my knowledge the above information is complete and accurate. I understand that reporting incomplete or inaccurate information can be dangerous to my health. _____

_____ _____

Signature of patient, parent, guardian, or personal representative | Date

_____ _____

Please print name of patient, parent, guardian, or personal representative | Date

THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY