

CENTER FOR DIABETES, ENDOCRINOLOGY & NUTRITION, INC

PATIENT REGISTRATION FORM

New Patient Information Update Date Completed _____

Name (First, MI, Last):		Home Ph:
Address (Street, City, State, Zip):		Social Security #:
Sex:	DOB:	Marital Status:
Employer:	Job Title:	Day Ph: Evening Ph:
SPOUSE OR GUARDIAN INFORMATION		
Name of patient's spouse or guardian (if patient is a minor):		Relationship to patient:
Address (Street, City, State, Zip) **if different than patient's**		
Phone #:	DOB:	Social Security #:
Employer:	Emergency contact number:	
REFERRING PHYSICIAN INFORMATION		
Referred by:	NPI Number:	Office Phone #:
Address:		
POLICY HOLDER INFORMATION		
Primary Insurance Carrier:	Secondary Insurance Carrier:	Tertiary Insurance Carrier:
Policy Holder's Name:	Policy Holder's Name:	Policy Holder's Name:
Group #:	Group #:	Group #:
ID#:	ID#:	ID#:
Specialist Co-pay amount:	Specialist Co-pay amount:	Specialist Co-pay amount:
Deductible amount:	Deductible amount:	Deductible amount:
INSURANCE VERIFICATION (for office staff to complete before visit)		
<input type="checkbox"/> Verify Eligibility	<input type="checkbox"/> Verify Primary or Secondary	<input type="checkbox"/> Authorization required from PMD?
<input type="checkbox"/> Verify Specialist Co-pay	<input type="checkbox"/> Verify Deductible & Amount Met	
<input type="checkbox"/> Confirm address for claim to be sent:		
<input type="checkbox"/> Verify Insurance Electronic Payer ID Number:		
Insurance verification completed by (staff name & date):		

AUTHORIZATION:

1. While at the Center for Diabetes & Endocrinology, I consent to all medical care, examinations and tests determined to be necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. If I refuse treatment that is suggested for me or do not complete any treatment protocol recommended to me, I will not hold the Center for Diabetes & Endocrinology or any individual responsible for any of the consequences.
 2. I authorize assignment of benefits due to be paid directly to Center for Diabetes & Endocrinology. I understand I am financially responsible for the charges not covered by this authorization.
 3. I authorize the Center for Diabetes to release any information required to my insurance company to process my claims.
 4. I hereby authorize my physician to release information to my referring doctor and/or Primary Care Physician(s).
 5. I understand all of the above and hereby state that the information provided is correct. I understand I am financially responsible for delays or denials of insurance claims due to incorrect information.
- My signature indicates that I have read the above and grant the request of authorizations.

Patient Signature: _____ Date: _____