PATIENT REGISTRATION

Patient Name: ____________________ Referring Dr. ____________ Primary Dr. ____________

Local Address: ____________________ How did you hear about us: ____________

City: ____________ State:________ Zip:____________ Local #: ____________

Permanent Address: ____________________ Permanent #:____________

City: ____________ State: ________ Zip: ____________ Work #: ____________

Email: ____________________ Cell #: ____________

SSN: ____________ Marital Status: (S) (M) (Other) (D) (W) Sex: (M) (F) Date of Birth: ____________

Emergency Contact: ____________ Phone: ____________ Relationship: ____________

Employment Status: (Full-time) (Part-time) (Unemployed) (Self-employed) (Retired) (Military)

Company: ____________________

Address: ____________________ City: ____________ State:________ Zip:________

Phone #: ____________ Fax: ____________ Contact Person: ____________

Responsible Party/Guardian: _______Patient _______ Other *If other, please complete this section*

Name: ____________________ Home #: ____________

Address: ____________________ Work #: ____________

City:____________State: ____________ Zip:____________ Cell #: ____________

Date of Birth: ____________SSN: ____________ Other #____________

Employer: ____________________

Insurance Information Do you have medical insurance?_____Yes _____No **Payment** is expected as services are rendered. What means of payment are you prepared to use today? ____Cash ____Check ____Visa/Master Card ____American Express

Primary: ____________________ Member ID #:____________ Group #: ____________

Name of Insured as it appears on card: ____________________ Insured's Date of Birth:____________

Secondary:____________________ Member ID #:____________ Group #: ____________

Name of Insured as it appears on card: ____________________

If insured person is other than the patient, please complete the following:

Patient relationship to insured: (Spouse) (Child) (Grandchild) (Niece/Nephew) (Parent)

Name: ____________________ Home #: ____________

Address: ____________________ Work #: ____________

City:____________ State: ____________ Zip:____________ Cell #: ____________

Date of Birth: ____________ SSN: ____________________ Other #: ____________

Information, Authorization for Treatment, and Assignment of Benefits

Consent for Treatment: I consent to the care and treatment by Dr. Cabiran. The treatment may include but is not restricted to medications, anesthesia, surgical and invasive procedures, lab, x-ray, or other studies that may be helpful in the performance of the patient's care. Authorization for Release of Medical Records: I authorize the release of any of all medical records or information, including psychiatric, drug, alcohol, HIV, and substance abuse records, to the referring physicians or agencies involved in the patient's care, insurance carriers or those involved in the payment of the patient's account, or others involved in the performance of quality assurance.

Assignment of Benefits and Guarantee of Account: I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that I am financially responsible for all co-payments and any charges that are not paid by my insurance. I authorize payment directly to Dr. Cabiran, M.D. all medical or surgical benefits otherwise payable to me under the terms of my insurance. In the event an account is turned over to a collection agency, I agree to pay all costs of collection including reasonable attorney's fees and hereby waiver all rights of exemption under the Constitution of the State of North Carolina/Georgia, I certify that the information I have reported with regard to my insurance coverage is correct.

Exposure to Diseases: I understand that if my physician(s), or any person employed by or under the direction and control of my physician(s), is directly exposed to my body fluids in any manner which may, according to the current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of theses test results who is exposed to by body fluids.

A photocopy of the authorization shall be considered as effective and valid as the original.

Circle one:

Patient Signature: ____________________ **(Patient) (Parent) (Guardian)** **Date:** ____________