Patient Registration

(Please Print)

1. Chart Number _____

2. Patient's Full Name _____ 3. Sex: ❑ M ❑ F
Last First Middle Name Preferred

4. Race: (please circle) American Indian, Asian, African American, Native Hawaiian or Pacific Islander, Caucasian, Other, Patient Declined

Ethnicity: (please circle) Non-Hispanic, Hispanic, Patient Declined Preferred Language _____

5. Patient's Social Security # _____ 6. Date of Birth _____ Age _____

7. Patient's Home Address _____
Street or Route City State Zip

Patient's Email Address _____

8. Primary Care Doctor _____ 9. Financial Responsibility: ❑ Patient ❑ Other

10. Referring Doctor _____

11. Patient's Home Phone (____)_____ Patient's Work Phone (____)_____ Patient's Cell Phone (____)_____

Preferred Notification Method: (please circle) Postal Mail, Phone, Web Message

12. Is the Patient Currently Employed? ❑ Yes ❑ No

Patient's Employer _____

Employer's Address _____
Street or Route City State Zip

13. Patient's Marital Status ❑ S ❑ M ❑ D ❑ W ❑ Sep. Spouse Name _____

14. Person we may contact in case of an emergency: Relationship _____

Name _____ Telephone # _____

Address _____
Street or Route City State Zip

INSURANCE INFORMATION – We cannot file your insurance without complete information and a copy of your insurance cards. Please bring your insurance card with you to the front desk when you have completed this form.

PRIMARY INSURANCE COVERAGE

15. Insurance Company _____ Address _____

16. Subscriber's Name _____ 17. Subscriber's Sex: ❑ M ❑ F

18. Subscriber's Date of Birth _____ 19. Subscriber's Social Security # _____

20. Patient's Relationship to the Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

21. Subscriber's Employer _____

22. Subscriber's ID # _____ 23. Group # _____

SECONDARY INSURANCE COVERAGE

24. Insurance Company _____ Address _____

25. Subscriber's Name _____ 26. Subscriber's Sex: ❑ M ❑ F

27. Subscriber's Date of Birth _____ 28. Subscriber's Social Security # _____

29. Patient's Relationship to the Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

30. Subscriber's Employer _____

31. Subscriber's ID # _____ Group # _____

OTHER INSURANCE ❑ Yes ❑ No

FINANCIAL AGREEMENTS AND AUTHORIZATION FOR TREATMENT: I hereby authorize Raleigh Medical Group, Cary Medical Group, Raleigh Adult Medicine,Wake Endoscopy Center and Wake Forest Endoscopy Center ("RMG/CMG/RAM/WEC/WF ENDO") and its physicians and such assistants as a physician may designate to furnish and perform on me or the patient stated above ("Patient") such medical care, examination and treatment as may be ordered by an RMG/CMG/RAM/WEC/WF ENDO physician in his or her medical judgment and such medical care, examination or treatment as is reasonable incident thereto. I hereby authorize direct payment to RMG/CMG/RAM/WEC/WF ENDO of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by RMG/CMG/RAM/WEC/WF ENDO to the Patient. I understand that, to the extent permitted by applicable law, I am, and I agree hereby to be, financially responsible to RMG/CMG/RAM/WEC/WF ENDO for charges not covered by this agreement, and I hereby guarantee payment to RMG/CMG/RAM/WEC/WF ENDO on demand for all such charges.

Signature _____ Please check one: ❑ Patient ❑ Authorized Representative

Date _____ ❑ Parent or Guardian of Minor

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize RMG/CMG/RAM/WEC/WF ENDO to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the Patient's examination and/or treatment to any insurance company, government agencies and their agents, and professional review organizations with which the Patient may have insurance coverage or which may be assisting in payment of the medical care provided by RMG/CMG/RAM/WEC/WF ENDO to the Patient. I also hereby authorize RMG/CMG/RAM/WEC/WF ENDO to release any medical information to any licensed physician, health care provider, or medical facility to which the Patient may be referred, admitted or transferred for further medical care. I understand that I may revoke this authorization by written notice at any time except to the extent that action already has been taken.

Signature _____ Please check one: ❑ Patient ❑ Authorized Representative

Date _____ ❑ Parent or Guardian of Minor