Carolinas Physicians Network
Carolinas HealthCare System

Patient Registration Form

PATIENT INFORMATION: MRN: ORG MRN:

Patient's Legal Name (***Last***, *First, Middle*)				Nickname
Social Security Number	Date of Birth	Sex M F	Marital Status ☐ Divorced ☐ Single ☐ Married ☐ Widowed ☐ Separated	
Primary Care Physician			Home Phone Number	
Patient Street Address *(Required)*			Cell Phone Number	
City	State	Zip *(+4 if known)*	E-Mail Address	
P.O. Box	P.O. Box Zip Code			
Employer Name			Employer Phone Number	Extension
Employer Address *(Street, P.O. Box)*			City State	Zip Code
Reason for Visit			Who referred you to us?	

Do we have your permission to leave a voice message (i.e. appointment reminders) at the contact number? ☐ Yes ☐ No
Do we have your permission to leave a voice message for normal test results at the contact number? ☐ Yes ☐ No

PRIMARY INSURANCE HOLDER / PERSON RESPONSIBLE FOR BILL:

☐ ***Check Here if Same As Above***

Name (***Last***, *First, Middle*)				Home Phone Number
Street Address *(Required)*			P.O. Box	P.O. Box Zip Code
City	State	Zip *(+4 if known)*	Social Security Number	
Date of Birth	Sex M F	Relationship ☐ Child ☐ Self ☐ Spouse ☐ Other ______		
Employer Name			Work Phone Number	Extension
Employer Street Address *(Required)*				
City	State	Zip *(+4 if known)*		

How are you paying today? ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance ☐ Workman's Comp. ☐ Company Account

EMERGENCY CONTACT:

Name (***Last***, *First, Middle*)			Home Phone Number	
Street Address *(Required)*				P.O. Box *(if applicable)*
City	State	Zip *(+4 if known)*	Work Phone Number	Extension
Relationship ☐ Child ☐ Spouse ☐ Other ______			Cell Phone Number	

FORM # CHS-020 Rev. 2/05

PLEASE COMPLETE BACK OF FORM

INSURANCE INFORMATION:

Please complete the section below.

Name of Primary Insurance			**Name of Secondary Insurance**		
Member/Policyholder (if different from patient): *(Last, First, MI)*			Member/Policyholder (if different from patient): *(Last, First, MI)*		
Member/Policyholder ID#	Date of Birth		Member/Policyholder ID#	Date of Birth	
Insurance Co. Phone Number	Group #		Insurance Co. Phone Number	Group #	
Insurance Co. *(Street Address/P.O. Box)*			Insurance Co. *(Street Address/P.O. Box)*		
(City)	*(State)*	*(Zip Code)*	*(City)*	*(State)*	*(Zip Code)*

AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND REFERRAL MEDICAL RELEASE:

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and compliant resolution. I authorize payment directly to Carolinas Physicians Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: ______________________________ Date ________ / ________ / ________

Office Use Only:

General Comment Section: