Advanced Internal Medicine, PC
AIM for Better Health

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PATIENT REGISTRATION FORM

(Please Print)

Name**:** _____ Birth date**:**_____
Address**:** _____ Phone**:**_____
_____ S.S. No**.**_____
_____ Email**:** _____

How did you hear about us? _____Cell Phone:_____

PERSON RESPONSIBLE FOR BILL

Name:_____ S.S. No._____
Address:_____ Relationship: _____
Date of Birth:_____ Phone:_____

EMPLOYERS

Patient Employed by:_____
Address:_____ Phone: _____

EMERGENCY CONTACT (Not Living with You)

Name:_____ Home Phone:_____
Address:_____ Work Phone: _____
Relationship to You:_____ Cell Phone:_____

Check all that apply:
I allow full disclosure of any of my medical or office information to the following persons:

☐ Spouse ☐ Other (name): _____ _____ DOB _____

_____
Phone City

INSURANCE

Primary:_____
Address: _____
Subscriber/Medicare Number: _____ Group Number:_____
Secondary:_____
Address: _____
Subscriber/Medicare Number: _____ Group Number:_____

Co-pay or non-insurance expenses are due at the time of service. There will be $30 charge for re-scheduling or canceling/no-show an appointment within 24 hours of scheduled appointment time.

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits. I authorize examination and treatment for this and all following physician visits.
ASSIGNMENT OF BENEFITS:
I authorize payment of medical benefits to Advanced Internal Medicine, PC for professional services rendered.
Release of Information:
I authorize the release of any medical information necessary to process claims or provide my care as required by law.
I allow review of my pharmacy history for coordination of care.
HIPAA: I have reviewed the office record and privacy policy and had my questions answered.
I allow the office to correspond with my home phone, email, or cell phone and allow the office to leave a message concerning reminders and routine reports.

Signed: _____ **Date:** _____