

PATIENT REGISTRATION

TREMONT MEDICAL CENTER, PA

Welcome to our office. Have you or any of your family members been patients here before today? YES [ ] NO [ ]

If yes: Name of Family Member: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

**IF THIS IS A WORK RELATED INJURY, PLEASE NOTIFY THE RECEPTIONIST NOW.**

PLEASE PRINT ANSWERS TO ALL QUESTIONS.

You will be asked to provide photo ID. All information will be strictly confidential.

Patient Name:			SSN:	
Last	First	Mi	-	-
Address:			City	State
_____			Zip Code	Date Of Birth:
Home Phone:			Cell Phone:	/ /
_____			_____	Sex: M [ ] F [ ]
If Out Of Town, Please Provide Local Contact Information:				
Name:		Phone:		Email:
_____		_____		_____
Employer Name:			Work Phone:	
_____			_____	
Address:			Extension:	
_____			_____	
<b>REASON FOR TODAY'S VISIT:</b>			Regular Physician:	
_____			_____	
_____			Phone: Last Visit:	
_____			_____	

If patient is under 18, please fill out the following completely.

Responsible Party Name:			SSN:	
Last	First	MI	-	-
Address :			City	State
_____			Zip Code	Date Of Birth;
Home Phone:			Cell Phone:	/ /
_____			_____	Relationship To Patient:
Employer Name:			Work Phone:	
_____			_____	
Address:			Extension:	
_____			_____	

I authorize Tremont Medical Center, P.A. to perform appropriate medical procedures as deemed necessary. I also understand Tremont Medical Center serves as an alternative to the hospital emergency department providing routine medical care and minor emergency treatment. It cannot provide the comprehensive care of a private physician. Therefore, I may be released before all of my medical or surgical conditions are known or treated.

\_\_\_\_\_

PATIENT, PARENT/GUARDIAN (if patient under 18 years old)

DATE

I have been offered a written copy of the Privacy Practice Notice for Tremont Medical Center.

\_\_\_\_\_

PATIENT, PARENT/GUARDIAN (if patient under 18 years old)

DATE

**PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE-INDICATE A PAYMENT METHOD**

Cash [ ] Check [ ] Debit [ ] Credit Card: Master Card [ ] Visa [ ] Am Ex [ ] Discover [ ]

## INSURANCE INFORMATION

**MEDICARE:** If you are covered by Medicare or a Medicare Advantage Plan, please provide the following

<b>Standard Medicare</b>  Yes [ <input type="checkbox"/> ] No [ <input type="checkbox"/> ]  Is This Primary? Yes [ <input type="checkbox"/> ] No [ <input type="checkbox"/> ]  If NO, we DO NOT FILE and payment at time of service is required.	<b>Medicare Advantage Plan</b>  Yes [ <input type="checkbox"/> ] No [ <input type="checkbox"/> ]  Is This Primary? Yes [ <input type="checkbox"/> ] No [ <input type="checkbox"/> ]  If NO, we DO NOT FILE and payment at time of service is required.
Secondary Insurance (if applicable) Insurance Company:	Medicare Advantage Plans do not allow secondary insurance.
<b style="color: red;">Please give Medicare/MC Advantage and secondary cards to the receptionist.</b>	
<b>MEDICARE LIFETIME SIGNATURE ON FILE</b>  I request that payment of authorized Medicare benefits be made on my behalf to Tremont Medical Center, PA for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION and its agents any information needed to determine these benefits payable for related services.	
PATIENT SIGNATURE _____	DATE _____

**TRICARE:** IF you are covered by Tricare, please provide the following:

IS TRICARE YOUR PRIMARY INSURANCE? Yes [ <input type="checkbox"/> ] No [ <input type="checkbox"/> ] If Tricare is NOT your primary insurance, we DO NOT FILE and payment at time of service is required.		
<b style="color: red;">Please give your Tricare card to the receptionist.</b>		
Sponsor Name:  Last _____ First _____ MI _____	Sponsor SSN:  - - -	
Sponsor Date of Birth:  / /	Sex: Male [ <input type="checkbox"/> ] Female [ <input type="checkbox"/> ]	Patient To Subscriber Relationship: Self [ <input type="checkbox"/> ] Spouse [ <input type="checkbox"/> ] Dependent [ <input type="checkbox"/> ]
I understand that I am responsible for my co-insurance, deductible, and other amounts allowed but not paid by Tricare. Payment is due within 30 days of billing.		
PATIENT SIGNATURE _____	DATE _____	

**If you have been sent by an employer or potential employer, please provide the following information.**

Employer Name: _____  Address: _____	Phone Number: _____  Contact Person: _____
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