Middlesex Community MedicalCare LLC.

Patient Registration Form

PATIENT INFORMATIONToday's Date__/__/____

Name_____
Last First Middle

Address_____
City State Zip

Home Phone ____-____-_____ Work Phone ____-_____-_____ Cell___-_____-_____

DOB___/___/_____ Age____ SS#____-____-_____ Sex _F_/_M_Marital Status____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name_____
Last First Middle

Address_____
CityStateZip

Home Phone____-____-_____ Work Phone____-_____-_____Cell____-____-_____

DOB___/___/_____ Age___ SS#____-___-____ Sex _F_/ M_Marital Status_____

INSURANCE INFORMATION

Primary Insurance Name_____ Name of Insured_____
Insured DOB___/___/_____ Insured's ID#_____ Group #_____
Employer Name_____ Employer address_____
Employer Phone____-____-____ Relationship of patient to insured_____
Secondary Insurance Name_____ Name of Insured_____
Insured DOB___/___/____ Insured's ID# _____ Group# _____
Employer Name_____ Employer address _____
Employer Phone ____-____-____ Relationship of patient to insured _____

Pharmacy Name _____ Phone ____-____-____
Emergency Contact_____ Relationship _____Phone ___-____-____
Referred By _____Primary Physician _____Phone ____-____-____

PATIENT AND RESPONSIBLE PARTY AUTHORIZATION

I authorize Middlesex Community Medical Care apply for benefits on my behalf for the covered services rendered and request that payments from the above named insurance company (ies) be made directly to: Meddlesex Community Medical Care for the treated person named. I certify that the information reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above named agent. I permit a copy of this authorization to be used in place of the original.

IN ALL CASES, PROFESSIONAL FEES ARE THE PATIENT, SPOUSE, GUARDIAN AND/OR PARENTS' RESPONSIBILITY. Finance Charge (no charge if paid in 30 days of billing date) is computed by a "Periodic Rate" of 1 ½ % per month, which is an ANNUAL PERCENTAGE RATE of 18% applied to the previous balance without deducting current payments and/or credits appearing on any given bill. Patient or responsible party (ies) further agree to pay any and all collection fees incurred and legal expenses, including but not limited to a all collection Agency and Attorney fees (at 33%), all court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest that may be adjudicated for the collection of past due debts.

Print Name: _____ Signature: _____Date: _____