Patient Registration Form

Karen Goodrich, M.D.

Patient's name:_____ Age:_____ Birth Date:_____

Home address:_____ Home phone:_____

City:_____ State:_____ Zip Code:_____

Social Security number:_____Cell phone:_____

Occupation:_____ Employer:_____

Address:_____Work phone:_____

If Minor, name of parent or guardian: _____ Phone:_____

Emergency Contact:_____ Relationship:_____Phone:_____

Primary Care Provider:_____ Phone:_____ Fax:_____

How did you find out about our office?_____

Name of prior physician:_____ Phone:_____

Spouse/partner's name:_____Age:_____ Birth Date:_____

Occupation:_____Employer:_____Phone:_____

Health Insurance:_____

I agree that payment is to be made at the time the service is rendered unless prior arrangements are made. I authorize Karen E. Goodrich, M.D., Inc. to bill my insurance and to receive the payment for medical benefits directly and to furnish information to the insurance carrier concerning my illness and treatments. Regulations pertaining to medical assignment of benefits apply. I understand that I am responsible for all amounts not covered by my insurance as well as services provided outside of the office. I further agree that in the event of non-payment, I will bear the cost of collections, court costs, and reasonable legal fees, should action be required. I agree that a photocopy of the authorization shall be valid as an original.

Patient's signature:_____Date:_____

Signature of Party Responsible for Payment:_____Date:_____

Acknowledgement of Receipt of Privacy Notice:

I have been presented with a copy of Karen E. Goodrich, M.D., Inc's Notice of Pivacy Policies, describing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and request the following restriction(s) concerning the use of my personal medical information: _____

_____

_____

Patient's/ Responsible Party's signature: _____Date:_____

Relationship:_____ Witnessed by:_____