Richard A. Kelly, MD

PATIENT REGISTRATION

(Please be as complete as possible)

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

SSN_____-_____-_____ Date of Birth: _____ Gender: ____ Marital Status: **S M W D**

Email Address: _____

Home Phone #: _____ Cell: _____Work: _____

Preferred Language: □ English □ Spanish Other _____ □ Declined

Race: (check one) □ American Indian □ Asian □ Native Hawaiian □ African American
□ White □ Hispanic □ Other □ Declined

Ethnicity: (check one) □ Hispanic or Latino □ Not Hispanic or Latino □ Declined

Pharmacy (name/addr/phone):_____

Employer: _____

Emergency Contact Name: _____ Relationship:_____

Emergency Contact Phone #: _____

Communication Preferences:

Do you authorize our office to leave messages at: HOME yes/no WORK yes/no CELL yes/no

Enable access to online Patient Portal for messaging and viewing test results? □ **Yes** □ **No**

Automated Communication Preferences (check boxes):

Health Notifications (recommend all)	□ Email	□ Phone	□ Text Message
Appointments (recommend all)	□ Email	□ Phone	□ Text Message
Announcements	□ Email	□ Phone	□ Text Message
Billing (recommend all)	□ Email	□ Phone	□ Text Message

Do not place any automated phone calls or emails □

_____ _____

Patient's Signature (Responsible Party) Date

Last Name: _____ First Name: _____ Middle Initial: _____

Responsible Party if Minor

Name: _____ DOB: _____ Phone: _____

Address: _____City/State/Zip: _____

SSN: _____-_____-_____

Insurance Information

Primary Insurance: _____ Phone: _____

Name of Insured: _____ SSN of Insured: _____-_____-_____

Date of Birth of Insured: _____ Relationship to Insured: _____

Secondary Insurance: _____ Phone:_____

Name of Insured: _____ SSN of Insured: _____-_____-_____

Date of Birth of Insured: _____ Relationship to Insured: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinic/physician. I understand that I am financially responsible for any balance. I also authorize Richard A Kelly, MD PA or insurance company to release any information required to process my claims. I accept full responsibility for any reasonable attorney's fees, court costs and legal fees associated with the collection of this account if there is a default in payment. I understand that Richard A Kelly, MD PA utilizes family billing; therefore the charges associated with any visit may be viewed by other family members. I have been offered a copy of Richard A Kelly, MD PA's Notice of Privacy Practices.

_____ _____

Patient's Signature (Responsible Party) Date