SOLID OAK ADULT AND PEDIATRIC CLINIC

PATIENT REGISTRAITION

Please fill in all information completely. If this does not apply, please put N/A.

Patient's Legal Name: Last____________________ MI_____ First____________________

Date of birth: ____________________ Social Security #____________________

Maiden Name ____________________ Preferred Name____________________

Patient's Mailing Address____

City____________________State____________________Zip____________________

Email Address (Required) ____

Home # (____)________________Cell # (____)________________Work #(____)________________

Sex: Male/ Female **Marital Status:** Single/ Married/ Widowed/ Divorced

Contact Preference: Home Phone/ Work Phone/ Mobile Phone/ Mail/ Portal

Ethnicity: ____________________Language: ____________________ Race:____________________

Emergency Contact: ____________________ Phone # (_____)____________________

Relationship to Patient: ____________________

PARENT OR GUARDIAN RESPONSIBLE FOR PATIENT

Responsible Party Name____

DOB:____________________ Responsible Party Social Security # ____________________

Billing Address____

City____State______________Zip________________

Home Phone #(____)____________________ Relationship to Patient ____________________

****Financial Policy****

Payment is due when services are rendered. **IF WE PARTICIPATE IN YOUR INSURANCE PLAN,** your co-pay or deductible needs to be paid at the time of visit. **IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE,** as a courtesy to you, our office will be happy to submit your claim to your insurance company for your reimbursement. Since we are not a party to the agreement with your insurance carrier, it is not our policy to contact carrier to establish why they have not paid or why they paid less than originally indicated. If your insurance carrier pays in excess of the balance, we will refund the credit amount to you. You will also be responsible for any other cost incurred while collecting any outstanding balances. By signing below you are accepting all financial responsibility for the above named patient.

****Authorization To Release Information ****

By signing below you also authorize Solid Oak Adult and Pediatric to release any information acquired in the course of your treatment necessary to process insurance claims.

Signature: ____ **Date:** ____________________

(Patient's signature is required if over the age of 14)