MIDTOWN
ENDOCRINE ASSOCIATES

REGISTRATION

Patients Legal Name: _____ Sex: M / F DOB: _____ Age: _____

Race: _____ Ethnicity: _____ Primary Language: _____

Phone Number: Home #_____ Cell # _____ Work #: _____

Primary Address: _____
City/ State / Zip code

Email Address: _____

Patient's Social Security # _____ Responsible Party: _____ Relationship: _____

Name and phone # of referring physician: _____

Name and phone # of primary physician: _____

Patient's employer/ school: _____ Occupation: _____

Emergency Contact information: _____ Phone # : _____

Address: _____ Relationship: _____

Can we contact this person regarding : Appointments: YES / NO Test Results: YES / NO Prescriptions: YES /NO

Primary reason for visit: _____

ALLERGIES TO MEDICATIONS: _____

Insurance Information

Primary Insurance Name: _____

Mail Claims to: _____
_____
_____

Insured Name: _____

Relationship: _____

Policy / Group # _____

Insured's Birth Date: _____

Insured's Employer: _____

Secondary Insurance: _____

Mail Claims to: _____
_____
_____

Insured Name: _____

Relationship: _____

Policy / Group #: _____

Insured's Birth Date: _____

Insured's Employer: _____

- **AUTHORIZATION TO CALL** above listed numbers or if unavailable, leave message on answering machine or adult family members
- **RELEASE OF INFORMATION** I hereby authorize Midtown Endocrine Associates or Desert Endocrinology to release any information required in the course of their examination or treatment for Medicare or insurance purposes.
- **AUTHORIZATION TO PAY:** I acknowledge full responsibility for all charges regardless of possible insurance coverage. I hereby authorize Midtown Endocrine Associates or Desert Endocrinology to obtain on my behalf, any insurance covered by **THE PRIVACY ACT** from my insurance company file(s). I hereby authorize payment directly to the physician for medical/surgical benefits. I am responsible for any charges/fees associated with collections of my account in the event that I default

Signed: _____ **Date:** _____