Quaker Medical Associates
Patient Registration Form

Date _____

Patient's Legal Name _____ SS# _____

Date of Birth ____ / ____ /____ Gender Male ____ Female ____ Marital Status _____

Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____

Street Address _____ City/State/Zip _____

Email Address _____ Occupation _____

Employer _____ Employer's Address _____

Emergency Contact _____ Phone ( )_____ Relationship _____

Responsible Party (if under 18 years of age) _____ Relationship_____

Address of Responsible Party _____ City/State/Zip_____

Spouse's Name _____ SS# _____ Date of Birth ____/ _____/_____

Occupation _____ Spouse's Employer _____

Spouse's Work Phone ( )_____ Is Spouse a Patient of Quaker Medical Associates? Y N

Who Holds Insurance? Please fill this out on that person

Primary Insurance Company _____ Is Medicare your Primary Insurance? Y N

Name _____ SS# _____ Date of Birth ____/ _____/ _____

Insured's Policy/ID Number_____ Group Number _____

Insurance Company Address _____ City/State/Zip _____

Secondary Insurance Company _____

Name _____ SS# _____ Date of Birth ____/ _____/ _____

Insured's Policy/ID Number_____ Group Number _____

Insurance Company Address _____ City/State/Zip _____

Authorization to release information and assignment of benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature: _____ ***Date:*** _____

I hereby authorize Quaker Medical Associates to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment form my insurance company be made directly to Quaker Medical Associates. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature: _____ ***Date:*** _____