Patient Intake and Registration Form

Patient Information

Full Name: ____

Preferred Nickname: ____

Date of Birth: ________________ **SS #** ____________________ **Gender**: ___________

Address: ____

City: ______________________ **State**: _______ **Zip code**: _____________

Home Phone _______________ **Cell Phone** _______________

Work _______________ **Email Address**: ____________________

How do you prefer to be contacted by All Pro Health? Home Cell Work Email

Please list any past medical history: ____

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Please list any past surgeries/hospitalization and dates: __________________________________

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By signing below, I acknowledge that the doctor, associate doctor and staff of the medical practice notes on this form, and hereafter referred to as DOCTOR, are authorized to treat the patient named on this form. DOCTOR is authorized to collect, use and exchange individually identified health information consisting of the patient's past, present and future medical information and personal information to treat the patient, communicate with patients, other Healthcare Providers, seek payment, carry out the necessary business functions and mandated reporting requirements. These situations and others, as well as your rights regarding this information, are explained in our a separate notice of privacy practices provided to you.

____________________________________ ____________________

Signature **Date**

(If the patient is under 18 years of age or unable to consent to treatment on their own behalf for whatever reason, the responsible party or guardian must sign here)

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Insurance Information

Primary Insurance Company: ____

Primary Insurance Mailing Address: ____
(Listed on the back of the insurance card)

Primary Insurance Policy/ID Number: ______________________________

Primary Insurance Group Number: ___________________

Insurance Subscriber Name: ________________________________ D.O.B. ________________

Relationship to Patient: ____

Secondary Insurance Company: ____

Secondary Insurance Mailing Address: ____
(Listed on the back of the insurance card)

Secondary Insurance Policy/ID Number: ______________________________

Secondary Insurance Group Number: ___________________

Insurance Subscriber Name: ________________________________ D.O.B. ________________

Relationship to Patient: ____

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Benefits Assignment and Release

I certify that I assign benefits directly to All Pro Health. I understand that I am financially responsible for charges not paid by my insurance company. I authorize this office to submit my insurance claims for me for services rendered and I authorize the use of my signature on submissions. I understand that I will be advised in advance of all services and/or supplies not covered by and under my insurance policy.

I, the undersigned, certify that I (or my dependent) have health insurance coverage with _________________________________ and assign directly to PROVIDER insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I authorize the use of this signature on all insurance claims submissions.

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Patient Name

_________________________________ _______________________

Signature of Patient **Date**

If the patient is under 18 years of age or unable to consent on their own behalf for whatever reason, please sign below:

_________________________________ _______________________

Signature **Date**