

CASTLEROCK DIAGNOSTIC & RESEARCH PHYSICIANS PATIENT REGISTRATION

PATIENT NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER
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DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	RELATIONSHIP TO GUARANTOR (IF OTHER THAN SELF, PLEASE FILL OUT GUARANTOR INFORMATION)
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ADDRESS	CITY, STATE, ZIP CODE
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HOME TELEPHONE NUMBER ()	E-MAIL	PAGER / CELL PHONE (CIRCLE) ()
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EMPLOYER	WORK TELEPHONE NUMBER
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ADDRESS	CITY, STATE, ZIP CODE
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GUARANTOR INFORMATION (IF PATIENT IS A MINOR)

RESPONSIBLE PART OR CUSTODIAL PARENT	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER
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DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	HOME TELEPHONE NUMBER ()	E-MAIL	PAGER/CELL (CIRCLE) ()
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ADDRESS	CITY, STATE, ZIP CODE
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EMPLOYER	WORK TELEPHONE NUMBER ()
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ADDRESS	CITY, STATE, ZIP CODE
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EMERGENCY CONTACT

CONTACT NAME (PERSON NOT LIVING WITH YOU)	RELATIONSHIP	HOME TELEPHONE NUMBER	WORK TELEPHONE NO.
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SPOUSE, PARENT(if applicable) OR OTHER

NAME (LAST, FIRST, MIDDLE)	HOME TELEPHONE NUMBER ()
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ADDRESS (IF DEFFERENT THAN PATIENT)	CITY, STATE, ZIPCODE
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EMPLOYER	WORK TELEPHONE NUMBER ()
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INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME	
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ADDRESS	CITY, STATE, ZIP CODE
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GROUP NUMBER	CERTIFICATE/POLICY NUMBER	EFFECTIVE DATE	RELATIONSHIP TO SUBSCRIBER (INSURED)
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SUBSCRIBER'S NAME	SUBSCRIBER'S EMPLOYER
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SECONDARY INSURANCE COMPANY NAME	
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ADDRESS	CITY, STATE, ZIP CODE
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GROUP NUMBER	CERTIFICATE/POLICY NUMBER	EFFECTIVE DATE	RELATIONSHIP TO SUBSCRIBER (INSURED)
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SUBSCRIBER'S NAME	SUBSCRIBER'S EMPLOYER
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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE – A detail of your rights and how your medical information will be used and disclosed by Castlerock Diagnostic Physicians is set forth in the NOTICE OF PRIVACY PRACTICES. A copy has been furnished to me and is posted in the clinic.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional service rendered. I have completed the above questions and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I request that payment of authorized medical benefits, if any, be made to Castlerock Diagnostic Physicians on my behalf for any unpaid services rendered by Castlerock physicians.

I authorize the release of medical information to the health plan indicated for information requested by the health plan to determine the payment of medical benefits. I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES

SIGNATURE	DATE
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