PADDER HEALTH SERVICES
www.padderhealth.com

Patient Registration Form

Name: ________________ _____________ _______________________________ **DOB:** ________________________
First MI Last Month / Day / Year

Address: ____ _______________________ ______ _________
Street City State Zip

Phone: __________________________ __________________________ __________________________ ___________
Home Cell Work Extension

Primary Physician: _________________________________ **Referring Physician:** _______________________________
Name Name

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

SSN: ______________________________ **E-mail Address:** ____

Employee Status: ☐ Full Time ☐ Part Time ☐ Not employed ☐ Self-employed ☐ Retired ☐ Disabled

Employer: _____________________ _____________________________________ __________________
Name Address Phone Number

In the event of an emergency please contact:

____________________________ _______________ _________________ ____________________________________
Name Relationship Phone No. Address

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic
☐ Native Hawaiian or Island Pacific ☐ Other: ______________________*(please specify)*

Language Spoken: _________________ **Pharmacy Name and Ph.Number:** ______________________________________

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: _____________________________ **Insured's Name:** ____
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Policy #: ____ **Group #:** ____
Employer: ____ **SSN:** _____________________ **DOB:** ___________________
Secondary Insurance: ________________________________ **Insured's Name:** ____________________________________
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Policy #: ____ **Group #:** ____
Employer: ____ **SSN:** _____________________ **DOB:** ___________________

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS & AUTHORIZATION FOR TREATMENT:

I consent to treatment necessary for the above named patient. I authorize Padder Health Services, PA to apply for benefits on my behalf for services rendered. I request payment from my insurance company to be made directly to the Providers. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, via mail, fax transmittal, and internet or electronic billing for this or any future claims.

I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of the pendency of claims thereon. I acknowledge that all proceeds of insurance are assigned to this office where applicable and that this office assumes no responsibility for the collection of any proceeds of insurance.

I hereby authorize the release of any pertinent information to my insurance company and any other doctors involved in my case. If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court cost, and attorney fees. I understand that all accounts with a balance over 30 days will be assessed a 1.5 percent late charge per month on the unpaid monthly balance.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: ____ **Date:** ________________________