

JAMES M. RHYNE, M.D., P.A. REGISTRATION FORM

(Please Print)

Today's Date:		Pt. Account#		PCP: Dr. Rhyme Dr. Ward Judy Keighron, R.N.,FNP-BC	
PATIENT INFORMATION					
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.
				Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	Parent Name if Minor:		Birth date:	Age:
					Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()
P.O. box:		City:		State:	ZIP Code:
Occupation:		Employer:		Employer phone no.: ()	
Chose clinic because/referred to clinic by (Please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance plan
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Hospital	
Other family members seen here:					

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:		Birth date:	Address (if different):		Home phone no.: ()
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:		Employer:	Employer address:		Employer phone no.: ()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance		<input type="checkbox"/> Medicare	<input type="checkbox"/> BC&BS	<input type="checkbox"/> Cigna	<input type="checkbox"/> Aetna
<input type="checkbox"/> Humana	<input type="checkbox"/> BC&BS State	<input type="checkbox"/> Partners BC&BS	<input type="checkbox"/> Medicaid	<input type="checkbox"/> United Health Care	
<input type="checkbox"/> Other					
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:
					Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()
			Work phone no.: ()
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize James M. Rhyme, M.D., P.A. or insurance company to release any information required to process my claims and to release any information to other health care provider to whom I have been referred. I do voluntarily consent to such diagnostic procedures and care deemed necessary by the physician, his assistant or designated consultants.</p>			
<hr style="border: none; border-top: 1px solid black;"/> Patient/Guardian signature			<hr style="border: none; border-top: 1px solid black;"/> Date