REGISTRATION FORM

Patient Information *Please complete this section for patient information only*

(Patient) Last Name	First Name
Date of Birth Sex: ☐ M ☐ F	Social Security #
Address	Home ( )
	Cell ( )
City State Zip	Work ( )

What is the relationship of the patient to the subscriber of the primary insurance? Please check one.
☐ **H**older of Insurance ☐ **S**pouse ☐ **D**ependent ☐ **O**ther ☐ No Insurance

Employed ☐ **F**ull Time ☐ **P**art Time ☐ **R**etired ☐ **N**o	Employer Name
	Employer Phone: ( ) Ext.
	(Responsible Party if patient is a minor)

Referring Physician Name

Responsible Party Information *Please complete this section for responsible party information only*

(Responsible Party) Last Name	First Name
Date of Birth	Social Security #
Address	Home ( )
	Cell ( )
City State Zip	Work ( )

Insurance Information

PRIMARY Insurance Carrier Name

Address City ST Zip			
Subscriber Name		Subscriber Employer	
Subscriber Sex ☐ M ☐ F	Date of Birth	Policy/Claim #	Group #

SECONDARY Insurance Carrier Name

Address City ST Zip			
Subscriber Name		Subscriber Employer	
Subscriber Sex ☐ M ☐ F	Date of Birth	Policy/Claim #	Group #

OTHER Insurance Carrier Name

Address City ST Zip			
Subscriber Name		Subscriber Employer	
Subscriber Sex ☐ M ☐ F	Date of Birth	Policy/Claim #	Group #

Your insurance company is now requiring that we gather additional information from our patients.
Please complete the following information.

Ethnic Group		
□ Not Hispanic or Latino	□ Hispanic or Latino	□ Unknown
Race		
□ White	□ American Indian or Alaskan Native	□ Unknown
□ Black or African American	□ Native Hawaiian or Pacific Islander	□ Refuse to answer
□ Asian	□ Multiracial	□ Other:
Preferred Language Spoken		
□ English	□ French	□ German
□ Spanish	□ Chinese	□ Other:
Religion (optional)		
□ Christian(Non-catholic, non-specific)	□ Lutheran	□ Hinduism
□ Roman Catholic Church	□ Orthodox	□ Judaism
□ Baptist	□ Pentecostal	□ Latter Day Saints
□ Methodist	□ Atheist	□ Other:
Marital Status		
□ Married	□ Single	□ Divorced
□ Widowed	□ Partner	□ Separated

For Healthcare reminders and messages, what is the best way to contact you?		
□ E-mail		
□ Mail - Use address on file		
□ Mail - Alternative Address:		
_____		
_____		
City	ST	ZIP
□ Phone - Home ( )		
□ Phone - Cell ( )		
□ Phone - Work ( )		
Who may we speak with about your healthcare management?		
Name:		Relationship:
Name:		Relationship:

Patient or Authorized Person's Signature:
I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plan to Louisville Concierge Medicine, PLLC.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNED_____DATE_____