CROWN
Surgery Medical Group, Inc.

Patient Registration Form Update

Today's Date:_____ Email: _____

Last Name:_____First Name:_____ Middle Initial:_____

Home Address:_____City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Business Phone:_____

Email:_____Social Security #:_____Sex: Male / Female

Marital Status:_____Date of Birth:_____ Age: _____

Preferred Language:_____

Occupation:_____Employer:_____

Emergency Contact Name:_____ Phone:_____Relationship to PT:_____

Emergency Contact Name:_____ Phone:_____Relationship to PT:_____

May we leave messages on your answering machine/voicemail? ☐ Yes ☐ No

I,_____understand that under Federal Law (HIPAA) this medical office may not release any medical information to any individual without my expressed written permission. Law enforcement and court order are two exceptions to this requirement. I, therefore give permission to Crown Surgery Medical Group to release medical information on my behalf to the following individual(s):

Name:_____ Phone:_____Relationship to PT:_____

Name:_____ Phone:_____Relationship to PT:_____

Name:_____ Phone:_____Relationship to PT:_____

INSURANCE INFORMATION (Please provide your insurance card upon arrival to your appointment)

Primary Insurance

Name of Policy Holder:_____

Insurance Name:_____

Subscriber ID:_____

Group #:_____

Employer:_____

Subscriber's Date of Birth:_____

Subscriber's Social Security:_____

Secondary Insurance

Name of Policy Holder:_____

Insurance Name:_____

Subscriber ID:_____

Group #:_____

Employer:_____

Subscriber's Date of Birth:_____

Subscriber's Social Security:_____

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Patient Medical History Form Update

Patient's Full Name:_____ Today's Date:_____
(Last) (First) (MI)

Medical Reason for Visit:_____

Surgical History:

1. _____
Type of Surgery Date Hospital Performed Surgeon

2. _____
Type of Surgery Date Hospital Performed Surgeon

3. _____
Type of Surgery Date Hospital Performed Surgeon

Other reasons you have been hospitalized:_____

_____

Other medical concerns since your last appointment:_____

Allergies/Sensitivities to Medication:_____

Current Medications: Prescription and Non-Prescription

Medication	Dose Amount	How Often Taken
1.		
2.		
3.		
4.		
5.		

Assignment of Benefits

I,_____, hereby authorize Crown Surgery Medical Group to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company, as referenced above, be made directly to the above-named provider (or in the case of Medicare Part B benefits, to myself or the party who accepts assignment.)

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 for this or any related claim, to the above-named billing-agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I authorize the provider or designated representative to contact me by telephone about appointments, billing, and medical care. As the patient or parent or guardian, I agree to the above terms and conditions.

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Date:_____Signature of Patient or Guardian:_____