

PRAIRIE MEDICAL GROUP
REGISTRATION/INSURANCE VERIFICATION FORM

Please present Insurance card and photo ID to receptionist

Name (Please Print): _____ Sex: _____

Social Security #: _____ Date of Birth: _____

Street Address: _____

City, State, Zip: _____

Home Phone: () _____ Work Phone: () _____

Employed by: _____ Occupation: _____

Employer's Address: _____

Marital Status: S M W D Name of Spouse: _____

In Case of Emergency, Contact: _____ Phone Number: () _____

Send Bill To (If different from above): _____

Street Address: _____ City: _____

State, Zip: _____ Referred by: _____

INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Employer: _____ Policy Holder's Social Security #: _____

Name of Secondary Insurance Company: _____

Name of Policy Holder if other than self: _____

I authorize my physician to release to my insurance carrier(s) information and/or provide copies of any and all of my medical records, including billing information, history, all diagnoses and information, including, but not limited to, psychiatric, HIV or HIV-related illness, the use of drugs or alcohol, for the purpose of obtaining payment for services rendered. I also authorize my insurance carrier(s) to make payment for these services to this office or its billing agent when assignment is accepted. I have completed this form fully and completely, and certify that I am the patient/guardian or an authorized general agent of the patient authorized to furnish this information. If I am the person authorizing this visit, it will ultimately be my responsibility for payment of services if not otherwise received.

Signature: _____ **Today's Date:** _____