

**LA PORTE REGIONAL PHYSICIAN NETWORK  
PATIENT REGISTRATION FORM**

Referring Doctor: \_\_\_\_\_

Account # \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Date: \_\_\_\_\_

**INFORMATION ABOUT PATIENT BEING SEEN TODAY:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Sex \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

**The best way to contact me by phone during the day is at:**  Home  Work  Cell **(Check One)**

How did you hear about our office?  Friend  Yellow Pages  Internet  Radio  Referral  Other

**RESPONSIBLE PARTY INFORMATION (IF NOT THE PATIENT)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Sex \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext.: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information**

Do you or your dependents have insurance coverage?  Yes  No

Do you have a secondary insurance  Yes  No

What type of health coverage do you currently have:

Medicare  Medicaid  Anthem  Other Insurance  No Insurance

What name is listed as the Insurance Holder: \_\_\_\_\_

Insurance Holder's date of birth: \_\_\_\_\_

Social Security Number of Insurance Holder \_\_\_\_\_

**Please hand your insurance cards to the front desk at the time of your visit.**

**OVER\*\*\* (PLEASE READ & SIGN REVERSE SIDE ALSO) \*\*\*OVER**

# LA PORTE REGIONAL PHYSICIAN NETWORK

## GENERAL CONSENT FOR TREATMENT, RELEASE OF INFORMATION, ASSIGNMENT, AND AGREEMENT TO PAY

I authorize the physicians, their associates, and employees of La Porte Regional Physician Network ("LRPN") to examine, diagnose, and treat my condition in the office, hospital, or emergency room.

**AUTHORIZATION TO RELEASE INFORMATION** I authorize La Porte Regional Physician Network to release any and all information contained in my medical record to any of the following: any third party payer; insurance company; pre-certification organization; managed care company; other health facilities or providers involved in my care; or for legitimate business purposes of LRPN related to receiving payment on my account; or for the purpose of payment for any treatment received, or for my further medical care.

I have received a written financial policy pamphlet. I understand that I am responsible for all services and supplies provided to me and on behalf of my dependents, regardless of insurance coverage. I understand that payment is due at the time of service, including co-pays and deductibles. I further agree to pay any and all costs and expenses incurred in the collection of this account including reasonable attorney fees.

**BY SIGNING THIS FORM** I consent that I have read, understand, and authorize the medical services to be provided, and the release of any required medical information to attain payment of my charges to be paid directly to LRPN, and that I am fully responsible for payment of all medical services and supplies that I or my dependents receive. I have read the above authorization and understand it and certify that no guarantee or assurance has been made as to the results that may be obtained.

  x    
PATIENT/PARENT/LEGAL GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

**CONFIDENTIALITY:** Due to the importance of protecting the confidentiality of the patient's medical information, we will not verbally disclose any medical information to a patient's family, friends, significant others, or any other individual unless the patient has authorized the release of the patient's medical information by specifying in writing the list of people who may obtain such medical or private information. Whenever the patient believes the list should be changed, the patient agrees to come to the office and complete a new form with the updated list of individuals who may receive the patient's health or medical information. **Please list below anyone you are authorizing to obtain verbal medical information about you. Please list in order of contact preference:**

Name	Initiated Date	Phone Number	Relationship To You	Discontinued Date
1.				
2.				
3.				
4.				

**How may we contact you with messages/test results? Please Indicate which you prefer:**

Leave message on machine \_\_\_\_\_ Leave message with \_\_\_\_\_  
(Person's name)  
Call at work or cell # \_\_\_\_\_ Other (specify) \_\_\_\_\_

**I do NOT want anyone other than myself given any information or contacted for any reason. Yes \_\_\_ No \_\_\_**

**Do you want us to call your home phone and leave an appointment reminder? Yes \_\_\_ No \_\_\_**

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE DATE

\_\_\_\_\_  
WITNESS DATE