

PATIENT REGISTRATION FORM

PATIENT MEDICAL RECORD NUMBER

PRACTICE NAME
MURAT BANKACI, M.D., P.C.

DATE

PATIENT INFORMATION (Please write information about the patient here and complete the form in black ink.)

PATIENT'S NAME (Last, First, Middle Initial)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	PRIMARY CARE PHYSICIAN	
PATIENT'S ADDRESS			PRIMARY CARE PHYSICIAN ADDRESS	
CITY	STATE	ZIP	EMPLOYER'S NAME	
TELEPHONE () ()		EMPLOYER'S ADDRESS		TELEPHONE () ()
CELL PHONE () ()		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		CITY
DATE OF BIRTH MO / DAY / YR		SOCIAL SECURITY NUMBER		STATE
AGE		EMPLOYMENT STATUS <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed		ZIP
		STUDENT STATUS: If 19 Years or Older: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not a Student		

INSURANCE INFORMATION (Please write information about the patient's insurance here.)

PRIMARY INSURANCE COMPANY NAME		
INSURANCE COMPANY'S ADDRESS		
CITY	STATE	ZIP
INSURED'S ID NUMBER	GROUP PLAN NUMBER	

SECONDARY INSURANCE COMPANY NAME		
INSURANCE COMPANY'S ADDRESS		
CITY	STATE	ZIP
INSURED'S ID NUMBER	GROUP PLAN NUMBER	

POLICYHOLDER INFORMATION

(Complete the information below if the PATIENT is NOT the POLICYHOLDER)

PRIMARY POLICYHOLDER'S NAME (Last, First, Middle Initial)		DATE OF BIRTH MO / DAY / YR	
PRIMARY POLICYHOLDER'S ADDRESS			SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
CITY	STATE	ZIP	TELEPHONE () ()
EMPLOYER'S NAME OR SCHOOL NAME		TELEPHONE () ()	
EMPLOYER'S ADDRESS			
CITY		STATE	ZIP
SOCIAL SECURITY NUMBER		RELATIONSHIP TO PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER	
EMPLOYER PLAN COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		IF CHAMPUS: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Deceased Branch of Service: _____	

Is the secondary policyholder the: Patient Primary Policyholder Other
(Complete the information below if you checked "Other")

SECONDARY POLICYHOLDER'S NAME (Last, First, Middle Initial)		DATE OF BIRTH MO / DAY / YR	
SECONDARY POLICYHOLDER'S ADDRESS			SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
CITY	STATE	ZIP	TELEPHONE () ()
EMPLOYER'S NAME OR SCHOOL NAME		TELEPHONE () ()	
EMPLOYER'S ADDRESS			
CITY		STATE	ZIP
SOCIAL SECURITY NUMBER		RELATIONSHIP TO PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER	
EMPLOYER PLAN COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		IF CHAMPUS: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Deceased Branch of Service: _____	

RESPONSIBLE PARTY INFORMATION

Responsible party is: Patient Primary Policyholder Secondary Policyholder
(Please complete the information below if the person responsible for paying the bill is not the PATIENT or the POLICYHOLDER.)

RESPONSIBLE PARTY'S NAME (Last, First, Middle Initial)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	SOCIAL SECURITY NO.	DRIVERS LICENSE NO.	LEGAL REPRESENTATIVE <input type="checkbox"/> Yes <input type="checkbox"/> No
RESPONSIBLE PARTY'S ADDRESS			EMPLOYER'S NAME		
CITY	STATE	ZIP	TELEPHONE () ()		
TELEPHONE () ()		RELATIONSHIP TO PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> OTHER		EMPLOYER'S ADDRESS	
				STATE	
				ZIP	

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN ON THE BACK OF THIS FORM. YOU SHOULD READ THOSE TERMS CAREFULLY.

X _____ Date _____



HOW DID YOU HEAR ABOUT US? _____

IN CASE OF AN EMERGENCY WHO SHOULD WE CONTACT? - (Please list someone living at a residence other than those listed on the reverse side)	Name _____	TELEPHONE:
	Address _____	Day - (____) _____
	CITY _____ STATE _____	Night - (____) _____
		RELATIONSHIP _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

I authorize the release of any information necessary to determine the liability for payment and to obtain reimbursement of any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including medicare, private insurance and other health plans to the practice named on the other side of this form.

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.

THANK YOU FOR YOUR COOPERATION