# PATIENT REGISTRATION FORM

| PATIENT MEDICAL RECORD NUMBER | PRACTICE NAME | DATE |
|---|---|---|
| | **MURAT BANKACI, M.D., P.C.** | |

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

PATIENT'S NAME (Last, First, Middle Initial) | SEX ☐Male ☐Female

PATIENT'S ADDRESS

CITY | STATE | ZIP

TELEPHONE ( ) | CELL PHONE ( ) | MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

DATE OF BIRTH ___/___/___ (MO DAY YR) | AGE | SOCIAL SECURITY NUMBER

PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN ADDRESS

EMPLOYER'S NAME | TELEPHONE ( )

EMPLOYER'S ADDRESS | CITY | STATE | ZIP

EMPLOYMENT STATUS ☐-Full Time ☐-Retired ☐-Part Time ☐-Not Employed

STUDENT STATUS: If 19 Years or Older: ☐-Full Time ☐-Part Time ☐-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 ☐Male ☐Female

CITY | STATE | ZIP | TELEPHONE ( )

EMPLOYER'S NAME OR SCHOOL NAME | TELEPHONE ( )

EMPLOYER'S ADDRESS

CITY | STATE | ZIP

SOCIAL SECURITY NUMBER | RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ PARENT ☐ OTHER

EMPLOYER PLAN COVERAGE ☐ YES ☐ NO | IF CHAMPUS: ☐Active ☐Retired ☐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 ☐Male ☐Female

CITY | STATE | ZIP | TELEPHONE ( )

EMPLOYER'S NAME OR SCHOOL NAME | TELEPHONE ( )

EMPLOYER'S ADDRESS

CITY | STATE | ZIP

SOCIAL SECURITY NUMBER | RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ PARENT ☐ OTHER

EMPLOYER PLAN COVERAGE ☐ YES ☐ NO | IF CHAMPUS: ☐Active ☐Retired ☐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 ☐Male ☐Female

RESPONSIBLE PARTY'S ADDRESS | STATE | ZIP

TELEPHONE ( ) | RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ PARENT ☐ GUARDIAN ☐ OTHER

SOCIAL SECURITY NO. | DRIVERS LICENSE NO. | LEGAL REPRESENTATIVE ☐Yes ☐No

EMPLOYER'S NAME | TELEPHONE ( )

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_____

SIGNED (Patient, or parent if under 18 years of age)

HOW DID YOU HEAR ABOUT US? _____

_____

Telephone:

**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 _____ Day - ( )

Address _____ Night - ( )

**CITY** _____ **STATE** _____ **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