Crossroads Health Center
Patient Registration Information
Please Fill Out Both Pages - Print Clearly

Patient's Social Security :_____**Date of Birth**:____/_____/_____Today's Date:_____/_____/_____

Patient's Name: _____**Home#:**_____**Work#:**_____**Cell#:**_____

Address:_____
City State Zip

Other Address (Mailing) if different than above:_____
City State Zip

If Minor Parent/Guardian:_____Contact Phone Number_____

Relationship to Patient:_____ **How did you hear about us: ( )Yellow Pages ( ) Radio ( ) T.V. ( ) Billboard ( ) Other**

Sex: ( ) Female ( ) Male ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Race: ( ) Caucasian ( ) African American ( ) American Indian ( ) Asian ( ) Hispanic ( ) Other

Patient's Employer: _____

Employer's Address:_____ Employer's Phone:_____

Spouse's Name:_____ Spouse's Social Security:_____

Spouse's Employer:_____

Employer's Address:_____ Employer's Phone:_____

Person To Contact In Case of Emergency:_____

Address:_____

Relation:_____**Phone**:_____

Insurance Information Insurance Coverage ____Yes _____No ____ Self Pay

PRIMARY
Insured:
_____Self_____ Spouse _____Other

Name of Insured:_____

Insured Date of Birth: _____

Insurance Name: _____

Policy No: _____SS#_____

Group Name/Number:_____

Employer:_____

Relation to Insured: ____Self _____Spouse
_____Child _____Other/Specify:_____

SECONDARY
Insured:
_____Self _____Spouse _____Other

Name of Insured:_____

Insured Date of Birth:_____

Insurance Name:_____

Policy No:_____SS#_____

Group Name/Number:_____

Employer:_____

Relation to Insured: ___Self ___Spouse
_____Child ____Other/Specify_____

****WE ASK YOUR PERMISSION TO MAKE A COPY OF YOUR INSURANCE CARD(S) FOR OUR FILES****

UNLESS ARRANGEMENTS HAVE BEEN MADE

1). Services are rendered to the patient, not the insurance company. As a courtesy of our office will bill your insurance if Proper information is received.

A). You are required to pay your co-payments at the time of each visit.
B). For any unpaid claims over 45 days, it is your responsibility to follow up with your insurance carrier, and the Balance due is considered due and payable.

2). It is your responsibility to notify our front desk staff of any insurance or address changes.

3). You will be responsible for any charges that occur if we are not notified.

PATIENT AUTHORIZATION

I authorize Crossroads Health Center to submit insurance claims using my signature on file below.

I authorize the release of medical information necessary in order to process this assignment on the claim.

I authorize payment of medical benefits to be paid directly to Crossroads Health Center for services described on the claim form.

I HAVE RECEIVED AND READ THE NOTICE OF PRIVACY PRACTICE _____
Signature

_____ _____
Patient Signature **Date**

Your Special Comments/Instructions to Us. **Referred By: _____**

DONOR STATEMENT

I, _____ have spoken to my family about organ and tissue donation. The following People have witnessed my commitment to be a donor. I wish to donate the following:

_____ Any needed organs and tissue.

_____ Only the following organs and tissues_____

Donor Signature: _____ Date: _____

Next of Kin_____Relation:_____

Telephone: (___) _____-_____