Red Rock Medical Group Patient Registration

Name: _____ Date: _____ Marital Status: _____ Birth Date: _____

Address: _____ Apt: ____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security Number: _____ Drivers License Number: _____

Employer: _____ Occupation: _____ Spouse's Name: _____

Spouse's Employer: _____ Spouse's Occupation: _____ Spouse's Birth Date: _____

Parent or guardian if under 18 years old: _____

Emergency contact not living in the same house: _____ Phone: _____

Address: _____ Relationship: _____

Who referred you to our office? _____

Primary Insurance Billing Information

Name of insurance company: _____ Name of Insured: _____

Address of insurance: _____ Phone: _____

Policy or ID number: _____ Group Name or Number: _____

Relationship of the insured to the patient: _____ **Insured Birth Date (required)**: _____

Secondary Insurance Billing Information

Name of insurance company: _____ Name of Insured: _____

Address of insurance: _____ Phone: _____

Policy or ID number: _____ Group Name or Number: _____

Relationship of the insured to the patient: _____ **Insured Birth Date (required)**: _____

Assignment of Insurance Benefits

I hereby authorize direct payment of medical/surgical benefits to Dr._____ for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Medicare-Medicaid

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be as valid as the original

Patient Name (please print): _____ **Date:** _____

Parent/Guardian (please print): _____ **Signature:** _____