Cathy J. Berry, MD and Associates

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PATIENT REGISTRATION FORM

(PLEASE PRINT)

Date:_____

Name:_____Sex:_____F_____M SS#:_____
Address:_____City:_____State:_____Zip:_____
Phone:_____Cell Phone:_____Age:_____DOB:_____
Marital Status: Single_____Married_____Divorced/Separated_____Widow/Widower_____
Patients Employer:_____Occupation:_____
Employers Address:_____Work Phone:_____
Emergency Contact:_____Phone:_____
Spouse / Significant Others Name:_____
Spouse / Significant Others DOB:_____SS#:_____
Spouse / Significant Others Employer:_____Occupation:_____
Employers Address:_____Work Phone:_____
Pharmacy Name & Address:_____Pharmacy Phone #:_____

INSURANCE INFORMATION

Primary Insurance Company:_____
Subscriber Name:_____ID#:_____
SS#:_____DOB:_____
Secondary Insurance Company:_____
Subscriber Name:_____ID#:_____

HIPAA DOCUMENTATION

(Please answer all questions below and then sign and date)

1. I acknowledge that I have been given the opportunity to read and / or receive a copy of Dr. Cathy J. Berry, MD & Associates Privacy Notice. Yes ☐ No ☐

2. Leave appointment message on:

			Leave other medical info on:		
Answering Machine?	Yes ☐	No ☐	Answering Machine?	Yes ☐	No ☐
Office Voice Mail?	Yes ☐	No ☐	Office Voice Mail?	Yes ☐	No ☐
W / Person Listed Below?	Yes ☐	No ☐	W / Person Listed Below?	Yes ☐	No ☐

3. Person(s) authorized to Discuss the Above & Relationship

_____ _____
_____ _____

Signature:_____ Date:_____

*****I authorize the release of any medical information necessary to process insurance claims, and the release of information back to my physician.
Signature:_____ Date:_____

*****I authorize the payment of medical benefits to above stated physician or supplier for services rendered.
Signature:_____ Date:_____