St. Clair Medical Services
Mt. Lebanon Internal Medicine

Today's Date: ________________

PATIENT REGISTRATION FORM

Patient Information

Name ____
Last First Middle

Sex ☐ Male ☐ Female

Address ____
Street Apt #

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

____
City State Zip

Marital Status
☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

Email ____

Home Phone ____________________________

Cell Phone ____________________________

Social Security # ____________________________

Birthdate ____________________________

Employment Status ☐ Full ☐ Part ☐ Retired ☐ Not Employed

Student Status ☐ Full Time ☐ Part Time

Employer ____________________________________

Work Phone ____________________________

Emergency Contact ____________________________________

Phone ____________________________

If a Minor, Parent/Guardian Name ____________________________

Phone ____________________________

Guarantor/Responsible Person Information

Name ____
Last First Middle

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Address ____
Street Apt #

Relationship to Patient ________________

____
City State Zip

Home Phone ____________________________

Cell Phone ____________________________

Insurance Information (please allow us to copy your card(s))

Primary

Ins Company Name______________________________
Policy Holder Information

Name ____________________________________

SS# ____________________________

Birthdate ____________________________

Relationship to Patient ____________________________

Secondary

Ins Company Name______________________________
Policy Holder Information

Name ____________________________________

SS# ____________________________

Birthdate ____________________________

Relationship to Patient ____________________________

ASSIGNMENT OF BENEFITS: I hereby assign all medical/surgical benefits to which I am entitled including major medical, Medicare, private insurance or other health plan benefits to the Mt. Lebanon Internal Medicine Division of St Clair Medical Services. 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 hereby authorize said assignee to release all information necessary to secure payment.
MEDICARE: I request that Medicare benefits be made on my behalf to Mt. Lebanon Internal Medicine Division of St Clair Medical Services for healthcare services furnished. I authorize any holder of medical information about me to release to HCFA and its agent any information needed to determine these benefits or the benefits payable for related services; I understand that my signature authorizes the release of medical information needed to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physicians agree to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and any non covered services. Co-insurance and deductible amounts are based upon the charge determination of the Medicare carrier.

____ ____________________________
Signature of Patient or if a minor, Responsible Party Date