Mt. Lebanon Internal Medicine Division
St. Clair Medical Services

Today's Date: _____

PATIENT REGISTRATION FORM

Patient Information

Name _____ Sex ☐ Male ☐ Female
Last First Middle

Address _____ ☐ Mr ☐ Mrs ☐ Miss ☐ Ms
Street Apt #

_____ Marital Status
City State Zip ☐ Single ☐ Married ☐ Divorced

Email _____ ☐ Widowed ☐ Separated

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 _____ ☐ Mr ☐ Mrs ☐ Miss ☐ Ms
Last First Middle

Address _____ Relationship to Patient _____
Street Apt #

_____
City State Zip

Home Phone _____ Cell Phone _____

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

Primary	Secondary
Ins Company Name_____	Ins Company Name_____
Policy Holder Information	**Policy Holder Information**
Name _____	Name _____
SS# _____	SS# _____
Birthdate _____	Birthdate _____
Relationship to Patient _____	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