EAST CAROLINA MEDICAL ASSOCIATES - REGISTRATION FORM

Please Print

Date: _____ Home Phone: _____

Patient Information:

Name: _____, _____ _____ Soc.Sec.#: _____
LAST FIRST INITIAL

Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____

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Primary Insurance:

Person responsible for Account: _____, _____ _____
LAST FIRST INITIAL

Relation to patient: _____ Birthdate: _____ Soc.Sec.#: _____

Address (if different than patient's):_____ Phone: _____

City: _____ State: _____ Zip: _____

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____ Soc.Sec.#: _____

Contract#: _____ Group#: _____ Subscriber#: _____

Names of other dependents covered under this plan: _____

Job Related Medical Illness: ☐ Yes ☐ No Worker's Compensation: ☐ Yes ☐ No

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Additional Insurance:

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name: _____ Relationship to Patient: _____ Birthdate: _____

Address (if different than patient's):_____ Phone: _____

City: _____ State: _____ Zip: _____

Subscriber Employed by: _____ Occupation: _____

Insurance Company: _____ Soc.Sec.#: _____

Contract#: _____ Group#: _____ Subscriber#: _____

Names of other dependents covered under this plan: _____

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Assignment of Release: **Name of Insurance Company(ies)**

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to ECMA all Insurance benefits, it any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I furthermore understand that I am responsible for any collection fees associated with balances on my account. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

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