# Patient Registration Form

**Patient Information**

**Patient Information:**

| | | |
|---|---|---|
| Last Name: | First Name: M.I.: | Previous Name (If applicable): |
| Mailing Address: | Apt #: | |
| City/State/Zip: | | |
| Home Phone: | Cell Phone: | Work Phone: |
| Preferred Method of Contact for Reminder Calls: (Please Select Only One Option). ☐ Home ☐ Cell ☐ Work | | Can we leave you a voicemail? ☐ Yes ☐ No |
| Date of Birth: | Sex: ☐ Female ☐ Male ☐ Transgender | |
| Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other: _____ | Social Security #: | |
| Employer Name: | Emergency Contact Name: | |
| Emergency Contact Phone #: | Relationship to Patient: | |

**Additional Information**

**Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)**

| | | |
|---|---|---|
| Email address: | | Preferred Language: ☐ English ☐ Spanish |
| Race (please select): ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Black or African American ☐ White ☐ Asian ☐ Other ☐ Decline | | Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline |
| Preferred Pharmacy Name: | Pharmacy Address or Cross Streets: | Pharmacy Phone Number: |

**Authorized Representatives**

**Authorization to Communicate Patient's Medical Information**

| Name | Relationship to Patient: | TYPE OF INFORMATION | | |
|---|---|---|---|---|
| | | Scheduling | Billing | Medical |
| | | | | |
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I certify that I have read and agree to Maurice A. Bell, M.D., Inc. (MAB Inc) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to MAB Inc all money to which I am entitled for medical expenses related to the services performed from time to time by MAB Inc, but not to exceed my indebtedness to MAB Inc. I authorize MAB Inc to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from MAB Inc by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. Comments submitted on surveys may be anonymously shared on the MAB Inc Public Website.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to MAB Inc. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

**I have reviewed a copy of Maurice A. Bell, M.D., Inc.'s Privacy Notice.** ☐ **(Initials)**

**Signature of Responsible Party:** _____ **Date:** _____

**Printed Name of Responsible Party:** _____ **Date:** _____