MidState Medical Group
A Hartford HealthCare Partner

PATIENT REGISTRATION SHEET

PATIENT NAME _____ HOME PHONE ( ) _____
LAST FIRST MIDDLE

HOME ADDRESS: _____
STREET TOWN/CITY STATE ZIP CODE

SOCIAL SECURITY# _____ DATE OF BIRTH _____/_____/_____ SEX M / F
Month Date Year

EMPLOYER NAME _____ EMPLOYER PHONE ( ) _____ EXT:_____

EMPLOYER ADDRESS _____
STREET CITY STATE ZIP CODE

EMERGENCY CONTACT_____

PRIMARY CARE
PHYSICIAN (PCP) _____ _____ PHONE ( ) _____
LAST FIRST CITY STATE

GUARANTOR - COMPLETE IF DIFFERENT FROM PATIENT **DATE OF BIRTH FOR GUARANTOR** _____/_____/_____

PATIENT RELATION TO GUARANTOR: 1) ☐ SELF 2) ☐ SPOUSE 3) ☐ DEP CHILD 4) ☐ OTHER _____

NAME _____ SS# _____

ADDRESS _____ PHONE ( ) _____
STREET CITY STATE ZIP CODE

EMPLOYER NAME _____ EMPLOYER PHONE ( ) _____

EMPLOYER ADDRESS _____
STREET CITY STATE ZIP CODE

PRIMARY INSURANCE INFORMATION

INSURANCE NAME _____

SUBSCRIBER NAME _____

SUBSCRIBER DOB ____/____/____ SUBSCRIBER SEX--> M ☐ F ☐

SUBSCRIBER SS# _____

SUBSCRIBER ID# _____

PATIENT RELATION TO SUBSCRIBER:
☐ SELF ☐ SPOUSE ☐ DEP CHILD ☐ OTHER _____

SECONDARY INSURANCE INFORMATION

INSURANCE NAME _____

SUBSCRIBER NAME _____

SUBSCRIBER DOB ____/____/____ SUBSCRIBER SEX--> M ☐ F ☐

SUBSCRIBER SS# _____

SUBSCRIBER ID# _____

PATIENT RELATION TO SUBSCRIBER:
☐ SELF ☐ SPOUSE ☐ DEP CHILD ☐ OTHER _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby assign payment of the medical and/or major medical benefits, if any, otherwise payable to me for this service, directly to the designated physician and/or MidState Medical Group. This authorization is valid for any and all insurance claims filed for me by MidState Medical Group to the insurance companies listed above. This authorization is valid from this date until written notice of cancellation is received in the offices of MidState Medical Group. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MIDSTATE MEDICAL GROUP AND/OR DESIGNATED PHYSICIAN FOR CHARGES NOT COVERED OR PAID BY THIS ASSIGNMENT.** I hereby authorize the designated physician to release any information acquired in the course of my examination and treatment to the insurance company(ies) listed above, and any other physician or health care facility where MidState Medical Group may refer me for further care.

_____ _____
Signature of Insurance Holder Date Signature of Responsible Individual Date