NEW CREATION HEALING CENTER
PATIENT REGISTRATION FORM

MEDICARE BENEFITS

Name: _____ Birth date: _____ Social Security # _____

Address _____ Mailing address if different _____

City, state & zip _____ Sex: M F Marital Status M S D W

Is it permissible to

Call home? **Y N** Leave message to call back if needed? **Y N** Home tel. _____

Call work? **Y N** Leave message to call back if needed? **Y N** Work tel. _____

Call cell phone? **Y N** Leave message to call back if needed? **Y N** Cell tel. _____

Email address: _____ Is it permissible to contact you via email: **Y** or **N**

Employer _____ Employer's address _____

Spouses name _____ Birth date _____ Who referred you to NCHC _____

Spouses employer _____ Telephone _____

EMERGENCY CONTACT

Name _____ Relationship to you _____

Home tel. _____ Work tel. _____ Cell tel. _____

I understand that NCHC staff may discuss my health with above listed person in an emergency situation only.

INSURANCE INFORMATION

Do you have insurance? Y or N Insurance Co. _____ ID# _____

Name of subscriber _____ Relationship to patient _____ Birth date _____

Address _____ City _____ State _____ Zip _____ Phone _____

Do you have secondary insurance? Y or N Insurance Co. _____ ID# _____

Name of subscriber _____ Relationship to patient _____ Birth date _____

Address _____ City _____ State _____ Zip _____ Phone _____

ONE TIME AUTHORIZATION FORM

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries/carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to New Creation Healing Center. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my medical treatment.

I authorize any holder of medical or other information about me to be released to my Medigap carrier any information needed for this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original and request payment of benefits to New Creation Healing Center.

I also authorize the release of any information pertinent to my care to Medicare and Medigap carriers for the processing of medical claims. I understand that the transmission of this information may be done by oral communication, paper claims or electronic submission.

Sign _____ Date _____

PCP ( ) Dr. Pearson ( ) Judy Misiaszek Revised 5/15