NEW CREATION HEALING CENTER
PATIENT REGISTRATION FORM

Name _____ Birth Date _____Social Security#_____

Address _____ Mailing address if different_____

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

Is it permissible to

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

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

Call cell phone? **Y N** Leave message to call us 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 _____ Work tel._____

Spouses employer _____ Address _____

If patient is a minor

Mother's name _____ Address_____Phone_____

Father's name _____ Address_____Phone_____

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 understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above information sheet. I certify this information is true and correct to the best of my knowledge. I will notify you of any change in my status of the above information. I also authorize the release of any information pertinent to my care to my insurance carrier 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. I hereby authorize the assignment of benefits to New Creation Healing Center.

Sign _____ Date _____

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