

Patient Registration Form

Last name _____ First name _____ date / / _____

Date of birth _____ SS# _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Home # _____ Office# _____ Cell# _____

Sex (circle): male female _____ Occupation: _____

Primary care physician (name address and phone#) _____

Referred by: _____

*******PLEASE PRESENT INSURANCE CARDS TO STAFF*****
PRIMARY INSURANCE INFORMATION**

Name of Insurance Co: _____

Policy# _____ Group# _____

Name of insured: _____ SS# _____ Insured DOB _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home # _____ Office# _____ Cell# _____

Assignment and Release

I, the undersigned, have insurance with _____ (Name of Ins co) and assign directly to Dr. Anne Hardick Dacko all medical benefits. I understand that I am financially responsible for all charges that are not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of insured/guardian: _____ **Date** / / _____

HIPAA PRIVACY NOTIFICATION

I, the undersigned, have been issued the HIPAA NOTICE OF PRIVACY PRACTICES. I fully understand that Anne Hardick Dacko, M.D. PLLC is required by law to maintain the privacy of my medical and health information. I acknowledge that the practice will use and disclose my health information for purposes of treating me, obtaining payment for services referred to me and conducting health care operations.

Signature of insured/guardian: _____ **Date** / / _____