APGCare

Patient Registration

Sex: M F

Name (Last) _____ (First) _____

SS#_____ Date of Birth _____

Street Address_____

City_____ State_____ Zip_____

Telephone: Home_____ Cell: _____ Office:_____

Referred By_____ Spouse Name _____

Emergency Contact _____Tel #_____ Relationship_____

Language: English /Spanish Other Ethnicity: Hispanic /Non-Hispanic Race: Asian,Black,White,Other

Email Address_____

Patient Employer Information

Employer Name_____ Tel #_____

Employer Address_____City/State_____Zip_____

Insured Person (If Not Patient)

Name _____Tel #_____

Street Address_____ City/State _____Zip_____

Relationship to Patient_____

Authorization to Release Information and Assignment of Benefit

I Authorize the release of any Medical Information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date_____Signature_____
(Patient or Guardian)

I hereby Authorize APGCare to apply for benefits on my behalf for covered services rendered by APGCare. I request that payment from my insurance company be made directly to APGCare providers that rendered the service.

I certify that the information I have provided with the regard to my insurance coverage is correct.

I permit a copy of this Authorization to be used in place of the original. This Authorization may be revoked by either me or my insurance company at any time in writing.

Date_____Signature_____
(Patient or Guardian)

A new form must be completed each year to update our records (even if there are no changes)
You must complete a form also each and every time there is a change in name, address or insurance coverage.