REGISTRATION FORM

PATIENT INFORMATION								
Patient's Last Name:	First:		M	Birth date	Sex:		Marital status (circle one)	
				/ /	❑ M	❑ F	Single/ Mar / Div / Sep / Wid	
Social Security no.:	Home number:			Cell number:			Work number:	
	( )			( )			( )	
Street address:		City:			State:		ZIP Code:	
Occupation:		Employer:					E-mail	

INSURANCE INFORMATION						
(On your first visit please give your insurance card to the receptionist.)						
Name of primary insurance	Subscriber's name:		Birth date:	Group no.:	Policy no.:	
			/ /			
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of secondary insurance (if applicable):	Subscriber's name:		Birth date	Group no.:	Policy no.:	
			/ /			
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work/cell phone no.:
		( )	( )
I grant permission for the following person or persons to receive verbal and/or written information about my health and medical treatment from the office of Green Mountain Internal Medicine, PLC.			
Name:	Relationship:	Phone;:	
Name:	Relationship:	Phone	

Please circle your response:
I **grant / do not** grant permission for this office to leave telephone messages concerning my medical information on my home cell phone answering machine.

I **grant/ do not** grant permission for this office to leave telephone messages concerning my medical information on my answering machine at my place of employment.

Medicare and or health insurance information release and assignment of benefits

This release, or a photocopy of the same, hereby authorizes this office to release any necessary medical information and / or copies of medical records required by my health insurance program and / or the Health Care Financing Administration for determination of benefits and for processing and settlement of claims. I request any payments or benefits under my health

insurance plan be made directly to Green Mountain Internal Medicine, PLC. This authorization will remain in full force and effect and apply to any past, present, or future health care services provided by the above providers, unless this authorization is revoked in writing.

In addition, I hereby acknowledge that I have received or read a copy of the Patient Rights and Confidentiality Policy and that my questions have been answered.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Green Mountain Internal Medicine, PLC or insurance company to release any information required to process my claims.

Signature_____Date_____