Cary Medical Group
Raleigh Adult Medicine
Raleigh Medical Group

PATIENT REGISTRATION (please print)

1. Chart Number
2. Patient's Full Name (Last / First / Middle / Name Preferred) 3. Sex: ☑ M ☐ F
4. Race: (Please Check) ☑ American Indian ☐ Asian ☐ African American ☐ Native Hawaiian or Pacific Islander ☐ Caucasian ☐ Other ☐ Declined
   Ethnicity: (Please Check) ☑ Non-Hispanic ☐ Hispanic ☐ Declined
5. Patient's Social Security # 6. Date of Birth: Age:
7. Patient's Home Address (Street or Route / City / State / Zip)
   Patient's Email Address
8. Primary Care Doctor 9. Financial Responsibility: ☑ Patient ☐ Other
10. Referring Doctor
11. Patient's Home Phone ( ) Patient's Work Phone ( ) Patient's Cell Phone ( )
12. Is the Patient Currently Employed? ☑ Yes ☐ No
    Patient's Employer
    Employer's Address (Street or Route / City / State / Zip)
13. Patient's Marital Status ☐ S ☐ M ☐ D ☐ W ☐ Sep. Spouse Name
14. Person we may contact in case of an emergency: Relationship
    Name Phone #
    Address (Street or Route / City / State / Zip)

INSURANCE INFORMATION – We cannot f le your insurance without complete information and a copy of your insurance cards. Please bring your insurance card with you to the front desk when you have completed this form.

PRIMARY INSURANCE COVERAGE

15. Insurance Company Address
16. Subscriber's Name 17. Subscriber's Sex: ☑ M ☐ F
18. Subscriber's Date of Birth 19. Subscriber's Social Security #
20. Patient's Relationship to Subscriber ☑ Self ☐ Spouse ☐ Child ☐ Other
21. Subscriber's Employer
22. Subscriber's ID # 23. Group #

SECONDARY INSURANCE COVERAGE

24. Insurance Company Address
25. Subscriber's Name 26. Subscriber's Sex: ☑ M ☐ F
27. Subscriber's Date of Birth 28. Subscriber's Social Security #
29. Patient's Relationship to Subscriber ☑ Self ☐ Spouse ☐ Child ☐ Other
30. Subscriber's Employer
31. Subscriber's ID # Group #

OTHER INSURANCE ☑ Yes ☐ No

FINANCIAL AGREEMENTS AND AUTHORIZATION FOR TREATMENT: I hereby authorize Raleigh Medical Group, Cary Medical Group, Raleigh Adult Medicine and Wake Endoscopy Center ("RMG/CMG/RAM/WEC") and its physicians and such assistants as a physician may designate to furnish and perform on me or the patient stated above ("Patient") such medical care, examination and treatment as may be ordered by an RMG/CMG/RAM/WEC physician in his or her medical judgment and such medical care, examination or treatment as is reasonable incident thereto. I hereby authorize direct payment to RMG/CMG/RAM/WEC of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by RMG/CMG/RAM/WEC to the Patient. I understand that, to the extent permitted by applicable law, I am and I agree hereby to be, f nancially responsible to RMG/CMG/RAM/WEC for charges not covered by this agreement, and I hereby guarantee payment to RMG/CMG/RAM/WEC on demand for all such charges.

Signature Please check one: ☑ Patient ☐ Authorized Representative
Date ☐ Parent or Guardian of Minor

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize RMG/CMG/RAM/WEC to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the Patient's examination and/or treatment to any insurance company, government agencies and their agents, and professional review organizations with which the Patient may have insurance coverage or which may be assisting in payment of the medical care provided by RMG/CMG/RAM/WEC to the Patient. I also hereby authorize RMG/CMG/RAM/WEC to release any medical information to any licensed physician, health care provider, or medical facility to which the Patient may be referred, admitted, or transferred for further medical care. I understand that I may revoke this authorization by written notice at any time except to the extent that action has been taken.

Signature Please check one: ☑ Patient ☐ Authorized Representative
Date ☐ Parent or Guardian of Minor

Submit

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