

New Mexico CLINICAL RESEARCH & OSTEOPOROSIS CENTER, INC.

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PATIENT REGISTRATION

PATIENT INFORMATION: PLEASE PRINT

Patient Name: _____	DOB: _____
Sex: _____ Social Security #: _____	Home Phone: (____) _____
Work Phone: (____) _____	Cell Phone: (____) _____
Mailing Address: _____	
City: _____	State: _____ Zip Code: _____ Married? <u>Y</u> / <u>N</u>
May we communicate with you by email? <u>Y</u> / <u>N</u> Email address: _____	

IN CASE OF EMERGENCY CONTACT:

Name: _____	Relationship: _____
Home Phone: _____	Work Phone/Cell Phone: _____

INSURANCE / PAYMENT INFORMATION:

Primary Insurance Carrier: _____	Insured Name: _____
Insured Date of Birth _____	Relationship: _____ Self _____ Spouse
ID #: _____	Group #: _____
Secondary Insurance Carrier: _____	Insured Name: _____
Insured Date of Birth _____	Relationship: _____ Self _____ Spouse
ID #: _____	Group #: _____
Tertiary Insurance Carrier: _____	Insured Name: _____
Insured Date of Birth _____	Relationship: _____ Self _____ Spouse

HOW DID YOU HEAR ABOUT US? PLEASE ✓

<input type="checkbox"/> Referral by provider: _____
<input type="checkbox"/> Friend <input type="checkbox"/> Newspaper <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Website <input type="checkbox"/> Other _____

I understand that I am financially responsible for all charges not covered by my insurance company or that if I am not eligible, or do not have insurance, I am responsible for all charges at time of service. There will be a \$25.00 charge for any returned check. If you are unable to make your scheduled appointment, please contact the office 24 hours in advance. A photocopy of this authorization may be honored.

Signature of patient or responsible party

Date

PLEASE COMPLETE THIS SIDE ONLY AND RETURN THIS FORM AND YOUR INSURANCE CARD(S), AT THE CHECK-IN COUNTER. THANK YOU!

I HAVE REVIEWED THE INFORMATION LISTED AND STATE THAT IT IS CURRENT AND CORRECT.

Signature of patient or responsible party

Date

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