ESTATE CLINICS by CMG

Patient Registration Form

Patient Information

Patient Information:

Last Name:	First Name:	M.I.:	Previous Name (if applicable)

Mailing Address: Apt #

City/State/Zip:

Home Phone:	Cell Phone:	Work Phone:

Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages:
(Please Select Only One Option) ☐ Voice ☐ Text

If Voice, Please Select Preferred Number:
☐ Home ☐ Cell ☐ Work

Previous Physician:	Date of Birth:	Sex: ☐ Male ☐ Female ☐ Transgender

Marital Status:
☐ Divorced ☐ Married ☐ Single ☐ Other________________________

Social Security #:

Employer Name:	Emergency Contact Name:

Emergency Contact Phone #:	Relationship to Patient:

Additional Information and Responsible Party

Responsible Party- If other than patient:

Last Name:	First Name:

Date of Birth:	Social Security #:	Phone:

Address of Person Responsible:

City/State/Zip:	Relationship to Patient:

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Email Address:

Race (please select):
☐ White ☐ American Indian or Alaska Native ☐ Asian
☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Other ☐ Decline

Ethnicity (please select one):
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil)
☐ Sign Language ☐ Spanish ☐ Russian ☐ Other

Preferred Pharmacy Name & Location:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to Estate Clinics by CMG payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Estate Clinics by CMG all money to which I am entitled for medical expenses related to the services performed from time to time by Estate Clinics by CMG, but not to exceed my indebtedness to Estate Clinics by CMG. I authorize Estate Clinics by CMG to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I choose to receive communications from Estate Clinics by CMG by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to PHMG. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Estate Clinics by CMG Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: X ______________________________ **Date:**

Printed Name of Responsible Party: X ______________________________ **Date:**

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