Integrated Health Concepts Patient Registration Form

Patient Demographic Information
Last Name: ______________________________
First Name: ______________________________
Middle Name or Initial: ____________
Address: ________________________________
City:______________________________
State: ______________ Zip: ________________
Home Phone: _________________________
Cell Phone: __________________________
Sex: F/M Date of birth: ______________
Social Security Number (required): __________________
Patient email: (required for portal use) Please print:
____

Language: _______________ Race: ________________
Ethnicity: _______________ Marital Status: _________

Guarantor Information (To whom statements are sent)
Name: __________________________________
Address: ________________________________
Relationship to patient: _____________________
Date of Birth: _______________________
Social Security Number: _____________________
Phone Number: ___________________________

Emergency Contact Information
Name: ____________________________
Relationship: ______________________
Phone: ____________________________

Employer Information:
Employer Name: ______________________
Address: ____________________________

Phone: ________________________________

Other
Referred By: ______________________________
Primary Care Provider: ___________________________
Preferred Contact Method:
Home/Work/Mobil/Email

Pharmacy Information
Name: ________________________________
Phone Number: ________________________

Insurance Information (Card(s) MUST be provided at appointment to be filed)

Primary Insurance
Plan Name: ______________________________________
Subscriber ID: ____________________________________
Group Number: ___________________________________
Last Name: ______________________________________
First Name: ______________________________________
Address: ____
City: ____________State: ___________ Zip: __________
Relationship to Policy Holder: _____________________

Secondary Insurance
Plan Name: ___________________________________
Subscriber ID: _________________________________
Group Number: _______________________________
Last Name: ____________________________________
First Name: ___________________________________
Address: ______________________________________
City: ____________State: ______ Zip: ___________
Relationship to Policy Holder:_________________

To the best of my knowledge the above information is complete and accurate:

Signed: ____ Date: ____

Office Staff Only

Date Received: ______________________
Entered By: __________________________

*****Please sign and date each line below*****

ACKNOWLDEGEMENT AND AUTHORIZATION

- **I have read and understand the HIPAA/Privacy Policy for Integrated Health Concepts**

  Signed: ________________________________ Date: __________________________

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

  Signed: ________________________________ Date: ___________________________

- **I authorize Integrated Health Concepts to release medical information required to process my claim.**

  Signed: ________________________________ Date: ___________________________

- **I authorize Integrated Health Concepts to obtain/have access to my medication history and to send prescriptions electronic.**

  Signed: ________________________________ Date: ____________________________

- **I authorize my providers office to contact me by mobile phone**

  Signed: _______________________________ Date: ____________________________

- **I understand that if I participate in a virtual visit (telehealth) that my copays, coinsurance and deductibles still apply and hereby give written consent.**

  Signed: ______________________________ Date: ___________________________