MCV Hospitals and Physicians
Sports Medicine Clinic registration form

Complete, accurate information is critical for proper billing. Please verify all information to prevent billing errors. Thank you!

Name: ____

Social Security number: _______________________________

Address: ____

Date of birth: _______________________________________

Email Address: ______________________________________

Home or cell phone: _________________________________

Employer: ____

Employer address: ___________________________________

Work phone: ____

Referring physician: _________________________________

Responsible party information

Are you the responsible party? Yes ___ No___

If no, please complete below:

Responsible party name: ______________________________

Relationship to patient: ______________________________

Address: ____

____

Home or cell phone: __________________________________

Is this worker's compensation-related? Yes ___ No___

If yes, please complete below:

Worker's comp contact: _____________________________

Phone number: ___________________________________

Address: ____

____

Date of accident: _________________________________

Worker's comp claim number: ________________________

Insurance information

Please bring your insurance card to our office so we can verify your coverage.

Primary insurance: ______________ **Policy number:** __________ **Group number:** __________ **Effective date:** ___________

Subscriber name: _________________________ Relationship to subscriber: ______ SSN: _____________________________

Subscriber DOB: ______________________ Subscriber's employer: ____

Subscriber's work address: __________________________ Subscriber employer phone number: ______________________

Subscriber employer phone number: ____________________________

Secondary insurance: ______________ **Policy number:** __________ **Group number:** __________ **Effective date:** _________

Subscriber name: _________________________ Relationship to subscriber: ______ SSN: _____________________________

Subscriber DOB: ______________________ Subscriber's employer: ____

Subscriber's work address: __________________________ Subscriber employer phone number: ______________________

Subscriber employer phone number: ____________________________

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Patient name: ___________________________________

SSN: ____

When did your problem start? ________________________
(specify month/year)

Family physician: __________________________________

Address: ____

____

Phone: ____

Authorization/Medicare lifetime signature agreement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or billing agents of the physician or supplier, any information needed for this or related Medicare claim. I permit a copy of this authorization to be sent in place of the original and I request payment under Medicare to be made to me or the physician, provider or supplier identified below for services furnished by that physician, provider or supplier.

I authorize the release of any medical information necessary to process this claim and payment of medical benefits to MCV Physicians for services rendered.

____ ________________________

Signature of patient (or parent of minor) Date