

Inter Island Medical Center Registration

_____ Date

Account Number

Patient Information:

Last Name _____ First Name _____ M.I. _____

Social Security Number _____ Birth Date _____

Sex: M F Marital Status: M S W D

Employment Status: Full Part Employer: _____

Mailing Address: _____
City State ZIP

Physical Address: _____
City State ZIP

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____

Do you need an interpreter? ___Yes ___No

If yes, what is your primary written/spoken language? _____

Insurance Policy Holder Information:

Last Name _____ First Name _____ M.I. _____

Social Security Number _____ Birth Date _____

Sex: M F Marital Status: M S W D

Employment Status: Full Part Employer: _____

Mailing Address: _____
City State ZIP

Physical Address: _____
City State ZIP

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____

Person to call in case of emergency if immediate family is not available:

Name _____ Phone: (____) _____

Billing Policy:

Inter Island Medical Center requires payment of copays at time of service. We will gladly submit claims to your insurance carrier(s) for payment, you the patient will assume responsibility for any unpaid balance(s).

Certification:

I certify that the answers to the questions on this registration form are true, correct, and complete, to the best of my knowledge. I understand and agree to the billing policy.

Signed _____ Date _____

Medicare Lifetime Signature on file:

I request that payment of authorized Medicare benefits be either made to me or on my behalf to Inter Island Medical Center for any services furnished me by the providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or payments payable for related services. A copy of this permit may be used in place of the original.

Signed _____ Date _____ Authorized from _____ to _____