AFFORDABLE HEALTHCARE P.C.

KELLY MCMAHON

3343 CENTER GROVE DRIVE, SUITE H

DUBUQUE, IA 52003

REGISTRATION FORM

PATIENT INFORMATION

NAME: _____ MAIDEN NAME: _____ GENDER: M / F

(LAST) (FIRST) (MIDDLE)

ADDRESS:_____

(STREET) (CITY) (STATE) (ZIP)

MARITAL STATUS: SINGLE / MARRIED / DIVORCED /WIDOWED / SEPARATED/ DOMESTIC PARTNERSHIP

DATE OF BIRTH: _____ SOCIAL SECURITY #:_____

EMAIL:_____

HOME PHONE: _____-_____-_____ CELL PHONE: _____-_____-_____

EMPLOYER AND POSITION (IF MINOR, PARENT'S): _____

NAME AND DATE OF BIRTH OF PARENT (IF A MINOR): _____

EMERGENCY CONTACT: _____

(NAME) (PHONE) (RELATIONSHIP)

SPOUSE'S NAME: _____SPOUSE'S PHONE #:_____-_____-_____ Spouse Date of Birth___/__/_____

SPOUSE'S EMPLOYEER: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:_____

SUBSCRIBER NAME AND DATE OF BIRTH: _____

SUBSCRIBER ID: _____ GROUP #: _____

SECONDARY INSURANCE COMPANY: _____

SUBSCRIBER NAME AND DATE OF BIRTH: _____

SUBSCRIBER ID: _____ GROUP #: _____

I understand that I am responsible for the costs of all services received, regardless of insurance coverage, including fees for failing to show for scheduled appointments and/or cancelling appointments with less than 24 hour notice. I authorize the release of any medical information necessary to process my claims to my insurance company. I also understand that if my insurance requires a referral, secondary opinion, or prior-authorization, I am responsible to inform my healthcare provider for these provisions. Failure to do so may result in my insurance carrier denying my claim, and I will be responsible for any balance resulting if this occurs. I acknowledge that additional fees may be required for patient and employer forms completed outside of a regular appointment. I acknowledge that all information listed above is true and correct to the best of my knowledge.

I have been informed that the Medically Managed Weight Loss Program is a cash-pay program that is not billed to insurance plans and I am responsible for all associated costs for this program at the time of service.

Signature:

_____Date:_____

(Parent/Guardian if patient is a minor)