GAMA Practices Registration Form

PATIENT'S INFORMATION

DATE _____ PHYSICIAN'S NAME _____

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE/ZIP _____

HOME/CELL PHONE # _____ WORK PHONE # _____

CONTACT #1

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE/ZIP _____

HOME/CELL PHONE # _____ WORK PHONE # _____

CONTACT #2

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE/ZIP _____

HOME/CELL PHONE # _____ WORK PHONE # _____

PHARMACY NAME _____ PHONE # _____

HEALTH INSURANCE

PRIMARY

INSURANCE COMPANY _____

ID NUMBER _____

GROUP NUMBER _____

SECONDARY

INSURANCE COMPANY _____

ID NUMBER _____

GROUP NUMBER _____

I understand that payment is expected at the time of visit unless previous arrangements have been made. I understand that failure to cancel an appointment with anyone in the office, without 24 hours' notice, may result in a charge for the missed appointment. This charge is not covered by insurance and I will be responsible for the bill. I understand that should my health insurance not reimburse the office for a non-covered service, I will be responsible for the bill. The office will try and notify me if a service is not covered by my insurance. I understand that it is my responsibility to see that proper referral is made from my primary care physician before a specialist is seen.

PATIENT'S SIGNATURE _____ DATE _____