OXFORD INTERNAL MEDICINE PATIENT REGISTRATION FORM

Patient Name _____ Patient Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Marital Status (circle one) M W S D Sex M F Social Security Number _____

Employer Name and Address _____

_____

Spouse or Responsibility Party Name _____

Spouse Date of Birth _____ Spouse Social Security Number _____

Spouse Employer Name, Address and Phone Number _____

_____

_____

Emergency contact not living with you _____

Relationship _____ Phone Number _____

How did you learn about practice? _____

Preferred Pharmacy : Local _____

Mail Order _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Oxford Internal Medicine all medical payments and benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance, this includes any/all injections that I receive.** I hereby authorize the release of all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____