CROSSROADS MEDICAL ASSOCIATES, LLC

PATIENT REGISTRATION - *Please Print Clearly* Doctor Name _____

PATIENT NAME First	Middle	Last			DATE OF BIRTH	AGE
HOME ADDRESS	APT. NO	CITY		STATE	ZIP CODE	
OCCUPATION	SOCIAL SECURITY NO.	MARITAL STATUS ☐S ☐M ☐D ☐W		SEX	HOME PHONE	
EMPLOYER	ADDRESS				WORK PHONE	
SPOUSE (OR PARENT)NAME	SPOUSE (OR PARENT) EMPLOYER				SPOUSE (OR PARENT) WORK PHONE	
ALLERGIES TO MEDICINES:						

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Our policy is that payment is to be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, check, Money Order, VISA or MASTERCARD.

I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above X_____

BILLING AND INSURANCE INFORMATION

SEND BILL TO	FIRST NAME LAST NAME		RELATIONSHIP TO PATIENT
	HOME ADDRESS	CITY	STATE
	EMPLOYER	WORK PHONE	HOME PHONE
PRIMARY INSURANCE	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP / CODE
	INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE
	SUBSCRIBER'S NAME	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS	WORK PHONE	SUBSCRIBER'S DATE OF BIRTH
SECONDARY INSURANCE	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP / CODE
	INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE
	SUBSCRIBER'S NAME	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS	WORK PHONE	SUBSCRIBER'S DATE OF BIRTH

PATIENT AUTHORIZATION

I, _____, hereby authorize Crossroads Medical Associates, LLC to apply for benefits on my behalf for services rendered. I request payment be made directly to Crossroads Medical Associates, LLC.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named insurance company. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time in writing.

_____ _____
Date Signature of Subscriber or Beneficiary

_____ _____
Date Signature of Subscriber or Beneficiary

_____ _____
Date Signature of Subscriber or Beneficiary

_____ _____
Date Signature of Subscriber or Beneficiary