

SWGA REGISTRATION FORM

(505) 999-1600
(505) 999-1595 fax

• PATIENT INFORMATION

Name: _____ Sex: M ___ F ___ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Martial Status: Single Married Separated Divorced Widowed

Patient's Employer: _____ Phone #: _____

Spouse's Name: _____ Spouse's Social Security #: _____ Spouse's D.O.B. _____

Spouse's Employer: _____ Phone #: _____

Emergency Information (person not living with you)

Name: _____ Phone #: _____

• INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

Address: _____ Phone #: _____

Certificate or I.D. #: _____ Group #: _____

Insured's Name : _____ Insured's Relationship to Patient: Self Spouse Child Other

SECONDARY INSURANCE CARRIER: _____

Address: _____ Phone #: _____

Certificate or I.D. #: _____ Group #: _____

Insured's Name : _____ Insured's Relationship to Patient: Self Spouse Child Other

PRIMARY CARE PHYSICIAN: _____ Phone #: _____

REFERRING PHYSICIAN: _____ Phone #: _____

You agree to permit your protected health information to be used and disclosed for purposes of treatment payment and health care operations. For more details about these uses and disclosures, please see our Privacy Notice.

We reserve the right to change our privacy policies described in the Privacy Notice. You may call us to receive an updated Notice.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. We are not required to agree with this request, but if we do we are bound by it.

You have the right to revoke your consent in writing. A revocation, however, will not apply to the extent we have taken action in reliance upon the use or disclosure of your information. A photocopy of this Authorization may be honored.

I acknowledge and assume responsibility for all charges incurred and for payment of services at the time rendered.

Signature _____

Date: _____