Phone: (828) 651-0121
Fax: (828) 651-0141

Asheville Medicine and Pediatrics
Patient Registration Information

Please PRINT AND complete ALL sections below!

600 Julian Lane; Suite 630
Arden, NC 28704

PATIENT'S PERSONAL INFORMATION

Marital Status (circle): Single Married Divorced Widowed **Sex (circle):** Male Female

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT 'S / RESPONSIBLE PARTY INFORMATION

Relationship to Patient (circle): Self Spouse Child Other: _____

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist after completing the section below.

PRIMARY Insurance Name: _____

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

Name of insured: _____ Date of Birth: _____ Relationship to insured: (circle) Self Spouse Child Other

Policy #: _____ Group #: _____ Copay: $ _____

SECONDARY Insurance Name: _____

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

Name of insured: _____ Date of Birth: _____ Relationship to insured: (circle) Self Spouse Child Other

Policy #: _____ Group #: _____ Copay: $ _____

PATIENT'S REFERRAL INFORMATION

Please tell us how you were referred to our practice.

Name: _____

Phone: (_____) _____

PHARMACY INFORMATION

Please tell us your preferred pharmacy. Complete as much as you can and we will fill in the rest.

Name: _____

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

Phone: (_____) _____ Fax: (_____) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

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

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly Asheville Medicine and Pediatrics, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____