SPARLIN HEALTH CARE
Since 1954

Sparlin Health Care

REGISTRATION FORM

V5.2015

PATIENT INFORMATION

(PLEASE PRINT) TODAY'S DATE _____/_____/_____

Thank you for choosing Sparlin Health Care for your health care needs. If you have any questions, please ask us. We will be happy to help.

Last Name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth Date: / /	Age:	Sex: ❑ M ❑ F

Street Address:	Apt #:	PO Box:	City:	State:	Zip:

Home Phone #: ( )	Cell Phone #: ( )	Other #: ( )
Social Security #:	Email Address:	

Patient Work Status: ❑ Employed ❑ Full-time Student ❑ Part-time Student ❑ Retired ❑ Other

Occupation:	Employer:	Work Phone No.: ( )

Employer Address:	City:	State:	Zip:

Spouse Name:	Spouse Employer:	Spouse Employer Phone No.: ( )

DO YOU HAVE MEDICAL COVERAGE? *(Check all that apply)* ❑ Auto ❑ Medicare ❑Group ❑Work Comp

INSURANCE INFORMATION (Please present your insurance card to the receptionist.)

Primary Insurance Name: _____

Ins. Address: _____

_____

Name of Insured: _____

Insured's ID#: _____

Group #: _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

Relationship of patient to the insured: _____

Secondary Insurance Name: _____

Ins. Address: _____

_____

Name of Insured: _____

Insured's ID#: _____

Group #: _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

Relationship of patient to the insured: _____

Other family members that are patients: _____

Who may we thank for referring you? ❒ Patient (Name: _____) ❒ MD (Name: _____)

❒ Internet ❒Yellow Pages ❒Area ❒Screening ❒ Doctor/Employee (_____)

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REGISTRATION FORM

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		Relationship to patient:		Home phone no.: ( )
Address:	City:	State:	ZIP Code:	Work phone no.: ( )
Primary Care Physician Name/Location:				Phone No.: ( )

This information is true to the best of my knowledge. I understand and agree that the insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am financially responsible for any balance. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. Information supplied or handled by this office (other than standard forms) will be charged 15%.

It is understood and agreed the amount paid to the doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office being on file where they may be seen at any time while a patient of this office. I also agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed condition or for any medical diagnosis.

Examination procedures are based upon clinical necessity. They may include vital signs, cranial nerves, and examination of eyes, ears, nose and throat, lungs, ranges of motion, palpation, neurological/vascular/orthopedic testing examination of thorax and abdomen and examination of extremities. Additional physical examination procedures may be performed when clinically indicated and the nature of the procedure(s) will be described prior to their performance.

I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions that may be considered necessary or advisable in the course of my health care.

The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications will be explained to me. I acknowledge that there is no guarantee or assurance as to the results that may be obtained from treatment.

ACKNOWLEDGEMENT OF RECEIPT OF "PRIVACY NOTICE" FOR PROTECTED HEALTH INFORMATION:
I acknowledge that I have received a copy of Sparlin Health Care's "PRIVACY NOTICE" for Protected Health Information on the date set forth below.

CONSENT FOR TREATMENT AND AUTHORIZATION OF X-RAYS:
To the best of my knowledge, I am not pregnant. ____(initial) I authorize Sparlin Health Care to perform such necessary radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

_____ _____

Patient Signature *Date*

_____ _____ _____

Guardian or Spouse's Signature Authorizing Care *Relationship to patient* *Date*