**John F. Carew MD, PC**

# REGISTRATION FORM

| *Patient Information* | | | | | | |
|---|---|---|---|---|---|---|
| First Name, MI | Last Name | | Gender | Date of Birth | | |
| Address | | | City | State | Zip | |
| Home Phone | Cell Phone | E mail address | | | | |
| Employer Name | Employer Address | | City, State | Zip | Work Phone | |
| Person to Contact in Case of Emergency | | | | | | |
| Emergency Contact's Name | Relationship | Home Phone | Work Phone | | | |
| *Your Physicians* | | | | | | |
| *Referring Physician's Name and telephone #* | | | | | | |
| Your Insurance Information | | | | | | |
| *PRIMARY Insurance Name* | *Insurance ID#* | | | | | |
| Address | Phone | State | Zip | | | |
| *Insured's Name* | *Insured's Date of Birth* / / | | | | | |
| Relation to Insured | | | | | | |

By Signing Below I Acknowledge that I Have Read and Agree to the Following:

- [x] Assignment of Benefits and Authorization to Release Medical Information
- [x] Acknowledgement of Receipt –Notice of Privacy Practice
- [x] Statement of Financial Policy
- [x] Procedures Sometime Not Covered
- [x] HIPPA and Privacy Policies

Scan QR code for All Acknowledgements

***Signature of Patient or Authorized Guardian*** ***Date***

Type name here to sign: / /