Starling PHYSICIANS
Healthcare the way it should be

PATIENT REGISTRATION

Date: ____________________

Patient Name: ______________________________ ❑ Male ❑ Female
LAST FIRST MI

Address: ______________________________

City: ____________ State: ________ Zip Code: ________

Email: ______________ Phone Number (____) ______________

Cell Phone (____) __________ SS Number: __________ Date of Birth: __________

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑ Minor/Student

Race: ❑ Black, African American ❑ Asian ❑ White ❑ American Indian ❑ Alaska Native
❑ Native Hawaiian, Other Pacific Islander ❑ Other ❑ Declined

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined

Primary Language: ❑ English ❑ Spanish ❑ Other: ______________

Patient Employed by: ______________ Occupation: ______________

Employer Address: ______________ Phone Number: ______________

Name of Emergency Contact: ______________________________

Relationship: ______________ **Telephone:** ______________

Spouse Employer: ______________ Occupation: ______________

Employer Address: ______________________________

Referred By: ______________ **Primary Care Physician:** ______________

Does your insurance require referrals and /or precertification? ______________

INSURANCE INFORMATION

Primary Carrier: ______________	Secondary Carrier: ______________
Identification Number: ______________	Identification Number: ______________
Name of Insured: ______________	**Name of Insured:** ______________
Employer: ______________	**Employer**: ______________
Group Name/Number: ______________	Group Name/Number: ______________
Insured's Date of Birth: ______________	**Insured's Date of Birth**: ______________
Insured's Social Security: ______________	Insured's Social Security: ______________
Relationship to Insured: ❑ Self ❑ Spouse ❑ Dependent	**Relationship to Insured:** ❑ Self ❑ Spouse ❑ Dependent

PLEASE TURN OVER ➔

Starling Physicians, PC

Patient Authorization Form

AUTHORIZATION AND RELEASE

I hereby authorize payment directly to Starling Physicians, PC of medical benefits otherwise payable to me. I understand I am financially responsible for charges not covered by this assignment. I hereby authorize Starling Physicians, PC to release information requested to support my claim.

FOR MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made on my behalf to Starling Physicians, PC for any services provided to me by that physician. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

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Signature of Patient, Parent or Guardian of Insured   Date