REGISTRATION

TROY INTERNAL MEDICINE, P.C.
4600 Investment Dr., Suite 300
Troy, Michigan 48098

Date _____

Home Phone _____ Cell Phone _____

Patient _____
Last Name First Name Middle Initial

Street Address _____

City _____ State _____ Zip Code _____

Email Address _____

Sex __M __F Age_____ Birth Date _____

Patient Employed By _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Do you have Medical Insurance? __No __Yes

Name of Primary Insurer _____

Contract # _____ Group # _____ Subscriber # _____

Name of Secondary Insurer (if any) _____

Contract # _____ Group # _____ Subscriber # _____

In case of emergency, who should be notified? _____ Phone # _____

How did you learn of our practice? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance

And assign directly to Troy Internal Medicine, P.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured /Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Troy Internal Medicine, P.C. for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full chare, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Insured /Guardian Date

Arcturus Health Care, PLC

Name_____ **DOB**_____ **Doctor**_____

Drug Allergies

Current Medications **Current Medications**

Please indicate any changes in medical history (i.e. medical problems, surgeries, etc.)

_____
_____
_____
_____
_____
_____

Other Physicians seen (Specialty and Phone Number Please)

_____
_____
_____
_____
_____
_____

Do you smoke? **Yes** **No** **Packs per day**_____ **Years**_____

Do you drink alcohol? **Yes** **No** **Drinks per week** _____