



The Diabetes Center

creating solutions for life

PATIENT REGISTRATION FORM

Primary Care Physician _____ Referring Physician _____

Do you wish to use Dr. Nicol as your PCP? Yes / No

How did you hear about us? _____

Patient's Name: (Last) _____ (First) _____ (Middle) _____		
Address: _____		Marital Status: S / M / D / W
City/State/Zip: _____		
Social Security: _____	Male / Female	Date of Birth _____ / _____ / _____
Home Phone: _____	Work: _____	Cell: _____ Email: _____
Emergency Contact: _____	Phone: _____	Relationship: _____

Primary Insurance: _____	ID#: _____
Subscriber: _____	
Subscriber SS#: _____	Subscriber Date of Birth: _____
Subscriber Employer/Group Name: _____	

Secondary Insurance: _____	ID#: _____
Subscriber: _____	
Subscriber SS#: _____	Subscriber Date of Birth: _____
Subscriber Employer/Group Name: _____	

INSURANCE ASSIGNMENT

I hereby consent to the release of information to my insurance carrier regarding my treatment at The Diabetes Center. I further authorize payment to be made directly to The Diabetes Center for any insurance benefits to which I am entitled. INITIAL: _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that The Diabetes Center will file my insurance claim as a courtesy; however, I will be financially responsible for any and all charges for services rendered regardless of my health insurance plan and the assignment of insurance benefits. INITIAL: _____

RELEASE OF MEDICAL INFORMATION

I hereby consent and authorize The Diabetes Center to release any and all information in my medical records to my Physician for continuity of care and to my Health Insurance Carrier for services provided in order to process medical claims. INITIAL: _____

NO SHOW OR CANCELATION APPOINTMENTS

I understand that I will be responsible for charges incurred for scheduled appointments that are not cancelled within 24-hours notice of the appointment time or for not showing for any lab or office visit scheduled appointment. INITIAL: _____

I agree that all of the information provided above is true and accurate. I also agree that all of the above posted office financial agreements and that all provisions noted above are accepted and will be honored at my request and authorization. This authorization is only applicable for 1 calendar year from the date noted with signature.

Signed _____	Date _____
Signed _____	Date _____
Signed _____	Date _____
Signed _____	Date _____
Signed _____	Date _____



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We are interested in learning how you made the decision to come to our office. Please select from the following options. More than one option may be selected if appropriate.

Yellow Pages

Billboard

Radio Advertisement

TV Advertisement

Recommended by a friend or relative: _____

Referred by a physician: _____

Newspaper or print ad: _____

Other (please give details: _____



PRIVACY NOTICE

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we must have your signed permission to leave any information with anyone other than you.

If you would like us to discuss your medical information with any person other than yourself, or give that person medical information, you must designate that person or persons below:

1. _____
2. _____
3. _____

Would you like us to leave information about your future appointments on your answering machine?

YES

NO

Signature: _____ Date: _____