EASTPORT HEALTH CARE, INC.
PATIENT REGISTRATION

NAME: _____ DATE:_____

MAILING ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE:_____SS#:_____EMAIL_____

DATE OF BIRTH:_____MARITAL STATUS: M S W D MALE_____FEMALE _____

EMPLOYER NAME, ADDRESS AND PHONE:_____

IF YOU HAVE A CASEWORKER PLEASE WRITE THEIR NAME HERE:_____

CONTACT in case of an emergency 1.)name_____phone#_____relationship_____

INSURANCE:
1.)_____POLICY#:_____GROUP#:_____

2.)_____POLICY#:_____GROUP#:_____

ANNUAL INCOME (please check appropriate box) MEMBERS IN HOUSEHOLD:_____

(under $10,830.00) ($10,831.00-$33,075.00) ($33,076.00-$44,100.00) ($44,101.00 and over)

HAVE YOU COMPLETED ADVANCED DIRECTIVES? Y N IF NOT, WOULD YOU LIKE TO?: Y N

I HERBY AUTHORIZE EASTPORT HEALTH CARE TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HERBY ASSIGN TO EASTPORT HEALTH CARE ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I CONSENT TO BE TREATED BY THE EASTPORT HEALTH CARE STAFF FOR MEDICAL CONDITIONS OR EMERGENCY SITUATIONS AS IS NESCESSARY. I UNDERSTAND THAT NO GUARANTEE HAS BEEN MADE AS TO THE RESULTS OF TREATMENT; BUT I MAY EXPECT A REASONABLE EXPLANTION OF MY CONDITION, THE PROPOSED TREATMENTS, COMPLICATIONS AND ALTERNATIVE.
WE MAY SEND AN APPOINTMENT REMINDER BY POSTCARD.

PATIENT'S SIGNATURE, IF PATIENT IS UNDER 18 YEARS PLEASE HAVE PARENT OR GUARDIAN SIGN.

X

(PLEASE COMPLETE PAGE 2)