**Rheumatology Specialists of Connecticut**

PATIENT# PATIENT REGISTRATION

***YOUR PERSONAL INFORMATION***

LAST NAME:_____ FIRST:_____ MI:_____
STREET ADD:_____ HOME PHONE:_____ GENDER:_□M____□F_____
APT#:_____ WORK PHONE:_____ BIRTH DATE:_____
CITY:_____ CELL PHONE:_____ SS#:_____
STATE: _____ ZIP CODE: _____ EMAIL:_____
RACE: _____ ETHNICITY: _____ ARE YOU A VETERAN? YES / NO

*PLEASE CIRCLE YOUR ANSWER BELOW*

MARITAL STATUS: M S D W WORKING?: FT PT RET NOT EMPLOYED STUDENT?: FT PT NOT A STUDENT

WORK ADDRESS:_____ OCCUPATION:_____

**PHYSICIAN INFORMATION**

PRIMARY CARE PHYSICIAN:_____ REFERRING PHYSICIAN:_____

**CLOSEST EMERGENCY CONTACT (NOT LIVING WITH YOU)**

NAME:_____ RELATIONSHIP:_____
PHONE NUMBER/S:_____

**YOUR SPOUSE/PARTNER/PARENT OR GUARDIAN INFORMATION**
(Required if you are not the primary subscriber)

LAST NAME:_____ FIRST:_____ RELATIONSHIP:_____
STREET ADDRESS – CITY, STATE, ZIP/HOME PHONE(IF DIFFERENT):_____

BIRTH DATE:_____ SS#:_____ CELL PHONE:_____

OCCUPATION/WORK ADDRESS:_____ WORK PHONE:_____

**INSURANCE INFORMATION**

| | Primary Insurance | Secondary Insurance | Tertiary Insurance |
|---|---|---|---|
| **Insurance Name** | | | |
| **Policy/ID#** | | | |
| **Group Number** | | | |

*****COPAY (IF APPLICABLE) IS EXPECTED AT THE TIME OF SERVICE*****

***Please read the following paragraph and sign below:***

I hereby assign all medical/surgical benefits to which I am entitled to Rheumatology Specialists of CT for services performed by them. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not said charges are reimbursed by insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. I further permit a copy of this authorization to be used in place of the original. I also understand that if this account must be turned over to an attorney for collections, I will be responsible for all attorney and court fees.

_____ _____
Signature of Patient/Guardian Date