ROBERT C BYRD CLINIC PATIENT REGISTRA

PATIENT INFORMATION

Social Security #_____ **Email Address** _____

First Name_____**MI**_____**Last Name**_____**Suffix**_____

Please provide your mailing address

Address_____**City**_____**State**_____**Zip**_____

Please Check Preferred Contact Number ☐ **Home** _____ ☐ **Mobile**_____ ☐ **Work**_____

Referring Provider_____ **Sex** ☐ Male ☐ Female **DOB**_____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown

Race ☐ Caucasian ☐ Hispanic ☐ Black ☐ Asian ☐ Native American ☐ Other_____

Ethnicity ☐ Latino/Hispanic ☐ Other ☐ Not reported/Refused

Language ☐ English ☐ Spanish ☐ French ☐ Other_____

Employment ☐ Employed ☐ Full Time Student ☐ Retired

Name of Employer _____ ☐ Military ☐ Part Time Student

☐ Self-Employed ☐ Veteran

EMERGENCY CONTACT

First Name_____MI_____Last Name_____Relationship_____

Home Phone_____Cell Phone_____Work Phone_____

I authorize Robert C. Byrd Clinic to provide medical care, either regular or emergency, as may be determined to be in the best interest of the patient-minor who is a member of immediate family. This authorization will continue to be in full force and effect until revoked by me in writing.

I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I hereby authorize Robert C. Byrd Clinic to release any information acquired in the course of my treatment necessary to process insurance claims.

I have been given the opportunity to review the RCBC Financial Policies and/or have access to the Patient Portal where I can review the Financial Policies.

I consent ☐ **YES** ☐ **NO** to be seen and treated by medical students.

_____

Authorized Signature Date

CONTINUED

RESPONSIBLE PARTY INFORMATION ☐ *Check Here If S*

Social Security #_____ **Sex** ☐ **Male** ☐ **Female** **DOB**_____

First Name_____ **MI**_____ **Last Name**_____ **Suffix**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown

Race ☐ Caucasian ☐ Hispanic ☐ Black ☐ Asian ☐ Native American ☐ Other_____

Ethnicity ☐ Latino/Hispanic ☐ Other ☐ Not reported/Refused

Language ☐ English ☐ Spanish ☐ French ☐ Other_____

Email Address_____ **Phone** _____ **Work**_____

Employer_____

Relationship to Patient:

☐ Child ☐ Husband ☐ Self ☐ Employee ☐ Aunt

☐ Wife ☐ Parent ☐ Special Dependent ☐ Grandparent ☐ Uncle

PATIENT INSURANCE INFORMATION ☐ *Check Here If Same As Patient Information*

Subscriber Information

Social Security #_____ **Patient's Relation to Subscriber** _____

First Name_____ **MI**_____ **Last Name**_____ **Suffix**_____

Address_____ **City**_____ **State**_____ **Zip**_____

DOB_____ **Sex** ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown

Race ☐ Caucasian ☐ Hispanic ☐ Black ☐ Asian ☐ Native American ☐ Other_____

Ethnicity ☐ Latino/Hispanic ☐ Other _____ ☐ Not reported/Refused

Employment ☐ Employed ☐ Full Time Student ☐ Retired

Name of Employer _____ ☐ Military ☐ Part Time Student

☐ Self-Employed ☐ Veteran

☐ Unemployed ☐ Disabled

Email Address_____ Phone _____ Work_____

ADDITIONAL INFORMATION

Do you have the following? **Living Will** ☐ Yes ☐ No **Medical Power of Attorney** ☐ Yes ☐ No

Would you like additional information about Advance Directives? ☐ Yes ☐ No