MDVIP (Internal Medicine-Dr. Jeffrey Schmidlein)

PLEASE PRINT CLEARLY PATIENT REGISTRATION FORM

Patient's first name: **Middle name:** **Last name:** **Suffix:** **Nickname:**

_____ _____ _____ _____ _____

Date of birth:_____ **Sex at birth(circle):** Male/Female **Preferred pronoun:** He/Him-She/Her-They/Them

Patient's address:_____**City**_____

State: _____ **Zip code:**_____ **Marital Status:** _____

Patient's cell #:_____ **Consent to text & call: YES / NO**

Patient's home #:_____ **Patient's email:**_____

Emergency contact name:_____ **Relationship to patient**:_____

Cell#: _____

Race (Circle all that apply, optional but helpful) **Ethnicity:**

Black/African American—Asian--Native American--Alaska Native--White Hispanic/Latino---Non-Hispanic---Unknown

Preferred Pharmacy:_____**Address**_____**Phone**_____

Insurance information *PLEASE PRESENT INSURANCE CARDS FOR SCANNING*

PRIMARY Insurance:_____ **Member ID**:_____

Name of Policy Holder:_____ **DOB**:_____ **Group #**:_____

Name of Employer:_____

****

SECONDARY Insurance: _____ **Member ID**:_____

Name of Policy Holder:_____ **DOB:** _____ **Group#**:_____

Assignment of Benefits:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for any non-covered services, co-pays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the physician to release any medical information required to process my claims.**
- **A fee for no shows or late cancellations may apply.**

Signature: _____ **Date:** _____