PATIENT REGISTRATION FORM (Please PRINT clearly)

PATIENT INFORMATION

Last Name	First Name	M.I.	Nickname

Date of Birth	Social Security Number	Gender

Mailing Address	City	State	Zip

Home Phone	Cell Phone	Work Phone

Employment Status	Employer/School

Marital Status	Race (Optional)

RESPONSIBLE PARTY (GUARANTOR OR SUBSCRIBER) INFORMATION

Relationship to Patient ❑ Self (If self, skip to Emergency / Next of Kin) ❑ Spouse ❑ Parent/Guardian ❑ Other

Last Name	First Name	Middle Initial

Date of Birth	Social Security Number	Gender

Mailing Address	City	State	Zip

Home Phone	Cell Phone	Work Phone

Employment Status	Employer

INSURANCE INFORMATION

Primary Insurance Company

Insurance/Policy No	Group No.	Effective Date

Subscriber Name	Subscriber Birthdate	Subscriber Social Security No.

Relationship to Patient ❑ Self ❑ Spouse ❑ Parent/Guardian ❑ Other

Secondary Insurance Company

Insurance/Policy No	Group No.	Effective Date

Subscriber Name	Subscriber Birthdate	Subscriber Social Security No.

Relationship to Patient ❑ Self ❑ Spouse ❑ Parent/Guardian ❑ Other

Other Insurance Company

Insurance/Policy No	Group No.	Effective Date

Subscriber Name	Subscriber Birthdate	Subscriber Social Security No.

Relationship to Patient ❑ Self ❑ Spouse ❑ Parent/Guardian ❑ Other

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name	First Name	Relationship to Patient

Home Phone	Work Phone	Cell Phone

PATIENT AGREEMENT

_____ (Initial) I hereby authorize American Medical Center and its agents to administer such medical examination diagnostic procedures and/or treatment that, in their judgment, may indicate to be advisable for the patients well being. I certify that no guarantee or assurance has been made as to the result that may be obtained.

CONSENT FOR MINOR

_____ (Initial) I, being the parent/guardian entitled to care, custody, and control of the foresaid minor, do hereby authorize and direct you to render such treatment to say minor in your judgment. It is understood that the above minor may occasionally appear at your clinic for examination or treatment, or both, unaccompanied by an adult, because of my (our) absence or unavailability.

_____ (Initial) I understand that the physicians, nurses or administrators may deem it advisable that a parent or guardian or other authorized adult be present with said minor for the purpose of assisting in the in the diagnosis or treatment. I agree to cooperate by being present with said minor whenever possible, especially when my presence is specifically requested.

_____ (Initial) This consent will be in effect until it is terminated by written notice received by American Medical Center where the original has been filed.

CONSENT FOR USE AND DISCLOSURE OF INFORMATION

_____ (Initial) I hereby authorize American Medical Center to request payment for covered serviced rendered by my billing agent (insurance or employer) and that payment be made directly to American Medical Center or if necessary to apply to the same for benefits on my behalf.

_____ (Initial) I, hereby authorize American Medical Center to give the necessary information from my medical records, including laboratory, radiology and diagnosis for payment purposes to my health insurance carrier or billing agent.

_____ (Initial) Employers/school representatives have the right to verify dates on work/school excuses.

_____ (Initial) I certify that I have read the foregoing and I am the patient or authorized patient representative and/or I am duly authorized as the patient's guarantor to execute the above and accept its terms. A copy of the authorization and certification may be used in place of the original and may be revoked by the patient or authorized representative at any time in writing.

FINANCIAL AGREEMENT

_____ (Initial) I fully understand that I am financially responsible for all co-payments, deductibles and services not covered by my insurance carrier. In consideration of any services rendered to me, I agree to pay the amount due to American Medical Center within thirty (30) days of billing date, and agree to pay any late charges and collection fees as appropriate.

_____ (Initial) I understand that if I am unable to keep my appointment, I must give **1 day notice** to American Medical Center or a **$25.00** cancellation charge will be assessed.

_____ _____

Patient/Guardian Signature **Date**

American Medical Center, LLC
1244 N. Marine Corps Dr., Ste. 101, Tamuning, GU 96913
Tel: (671) 647-8262 Fax: (671) 647-8257