Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:______________________________________

First Name:______________________________________

Middle Name: ___________________________________

Address: _______________________________________

City: ________________________ State____Zip: ________

Home Phone: _____________Work Phone:_____________

Mobile Phone:________________ Sex: ______________

Date of Birth: _________ Social Security #:_____________

Patient email: ___________________________________

Guarantor Information (to whom statements are sent)

Name: ____

Address: ____

City: _________________________ State____Zip:_________

Relationship to patient: ___________________________

Date of Birth: _________ Social Security #:______________

Phone: ( ) _______ - _____________

Emergency Contact Information

Name:____

Relationship: ______________________________________

Phone: ( ) _______ - _____________

Mobile Phone:( ) _______ - _____________

Primary Insurance Information

Insurance Plan Name: ____

Policy Holder (if other than patient)

Name: ____

Address: ____

City: _________________________ State____Zip:_________

Date of Birth: ___________________ Sex: ____M ____F

Policy Information

Patient's relationship to policy holder: _______________________

ID/Certification No.: _____________________________________

Policy/Group No.: _______________________________________

Employer Name: ____

Secondary Insurance Information

Insurance Plan Name: ____

Policy Holder (if other than patient)

Name: ____

Address: ____

City: _________________________ State____Zip:_________

Date of Birth: ___________________ Sex: ____M ____F

Employer Name: ___________________________________

Policy Information

Patient's relationship to policy holder: _______________________

ID/Certification No.: _____________________________________

Policy/Group No.: _______________________________________

ASSIGNMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to Community Care of West Virginia, Inc.**
- **I consent to any services rendered to me or to my dependents under a provider's orders.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance as specified on the Financial Agreement.**
- **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 Community Care of West Virginia, Inc. to release any medical information required to process this claim.**
- **I authorize my provider's office to contact me by telephone to remind me of my appointments.**
- **A fee for no shows may apply.**

The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Signed____ **Date:**____________________