

# PATIENT REGISTRATION SHEET (PLEASE PRINT)

PL PHYSICIANS, INC.  
MOLLY CASTILLE, MD

DATE: \_\_\_\_\_

PATIENT INFORMATION		
LAST NAME:	FIRST NAME:	MI:
ADDRESS:	CITY, STATE:	ZIP CODE:
HOME PHONE:	DATE OF BIRTH:	SSEX:
MARITAL STATUS:	SOCIAL SECURITY:	
EMPLOYER:	WORK PHONE:	CELL PHONE:
EMPLOYER ADDRESS:	CITY, STATE:	ZIP CODE:
REFERRING PHYSICIAN:	PRIMARY CARE PHYSICIAN:	
PHARMACY NAME:	PHARMACY LOCATION:	

EMERGENCY CONTACT		
LAST NAME:	FIRST NAME:	MI:
ADDRESS:	CITY, STATE:	ZIP CODE:
HOME PHONE:	WORK PHONE:	RELATIONSHIP TO PATIENT:
EMPLOYER:	EMPLOYER ADDRESS:	

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)		
LAST NAME:	FIRST NAME:	MI:
ADDRESS:	CITY, STATE:	ZIP CODE:
HOME PHONE:	WORK PHONE:	RELATIONSHIP TO PATIENT:
EMPLOYER:	EMPLOYER ADDRESS:	

INSURANCE INFORMATION		
PRIMARY INSURANCE:	SECONDARY INSURANCE:	
SUBSCRIBER NAME:	SUBSCRIBER NAME:	
POLICY NUMBER:	POLICY NUMBER:	
DOB:                      SSN:	DOB:                      SSN:	
RELATIONSHIP TO PATIENT:	RELATIONSHIP TO PATIENT:	

**Assignment of Insurance Benefits:** I hereby authorize payment to this practice for any benefits payable to me for healthcare services provided to the client/patient at this practice, to be paid directly to the practice. I understand that if health insurance information is provided, this in no way relieves me of financial responsibility for services rendered now or in the future of this practice.

**Guarantee of Payments:** I understand that I am financially responsible for all amounts payable with regards to fees for healthcare services rendered now and in the future by this practice. In the event of non-payment by me of any amount due to this practice after 90 days, I agree that in addition to the original amount due, I am fully responsible to pay collection fees of 33 and 1/3% of the amount due, court costs and reasonable attorney's fees incurred by this practice if required to collect my debt owed.

**Signature of Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_