

**Quaker Medical Associates  
Patient Registration Form**

Date \_\_\_\_\_

Patient's Legal Name \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_ / \_\_\_ / \_\_\_ Gender Male \_\_\_ Female \_\_\_ Marital Status \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Street Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Email Address \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Relationship \_\_\_\_\_

Responsible Party (if under 18 years of age) \_\_\_\_\_ Relationship \_\_\_\_\_

Address of Responsible Party \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Spouse's Name \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_

Occupation \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Spouse's Work Phone ( ) \_\_\_\_\_ Is Spouse a Patient of Quaker Medical Associates? Y N

***Who Holds Insurance? Please fill this out on that person***

**Primary Insurance Company** \_\_\_\_\_ Is Medicare your Primary Insurance? Y N

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_

Insured's Policy/ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_

Insured's Policy/ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

***Authorization to release information and assignment of benefits***

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I hereby authorize Quaker Medical Associates to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Quaker Medical Associates. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_