MILWAUKEE HEALTH SERVICES, INC.

PATIENT REGISTRATION

PAGE 1 OF 2 Interpreter Needed? ❑ Yes ❑ No

Specify Language_____

NAME			
DOB	AGE	RACE	SEX
Chart:			
Date:			

Patient Information

Last Name_____ First and M.I._____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Date of Birth_____

Email_____

Sex:	Annual Household Income:			Are You a Veteran?	
❑ Female	❑ 0-$10,000	❑ $10,001- $20,000	❑ $30,001-$40,000	❑ Veteran	❑ Veteran/EIP
❑ Male	❑ $40,001-$50,000	❑ $20,001-$30,000	❑ $50,001 and Over	❑ Veteran/Homeless	❑ Veteran/SAMHSA

Race:
❑ Black ❑ White ❑ Asian ❑ American Indian & White ❑ Asian & White
❑ Native Hawaiian/Pacific Islander ❑ American Indian/Alaskan Native & White
❑ Black & White ❑ American Indian/Alaskan Native & Black ❑ Other Multi-Race
Ethnicity: ❑ Hispanic ❑ Other (specify):_____

in Household (including patient)_____

Marital/Relationship Status:
❑ Single ❑ Divorced ❑ Legally Separated
❑ Wldowed ❑ Married ❑ Domestic Partnership

Employer Information

Employer Name_____ Phone_____

Employer Address_____ City_____ State_____ Zip_____

Emergency Contact Information

Contact Name_____ Relationship to Patient_____

Home Phone_____ Cell or Work Phone_____

Responsible Party (if different from patient)

Last Name_____ First and M.I._____ Maiden Name_____

Home Phone_____ Work Phone_____ Cell Phone_____

Social Security Number_____ Employer Name_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Information

Primary Insurance Company Name		Primary Insurance Company Name	
Policy Number	Group Number	Policy Number	Group Number
Subscriber Name	Subscriber Birth Date	Subscriber Name	Subscriber Birth Date
Insured Address if Different from Patient		Insured Address if Different from Patient	
Coverage Effective Date	❑ Retired ❑ Employed	Coverage Effective Date	❑ Retired ❑ Employed
Relationship of Insured to Patient: ❑ Self ❑ Spouse/Significant Other ❑ Parent ❑ Other		Relationship of Insured to Patient: ❑ Self ❑ Spouse/Significant Other ❑ Parent ❑ Other	

MILWAUKEE HEALTH SERVICES, INC.

PATIENT REGISTRATION

NAME			
DOB	AGE	RACE	SEX
Chart:			
Date:			

PLEASE READ AND SIGN THE AUTHORIZATION BELOW

I hereby authorize Milwaukee Health Services, Inc., and any of its Clinics to release to any and all public and private health care insurers, information from my medical record for legitimate purposes of payment of my bill. I understand that the information may include diagnosis and treatment for physical and/or mental illness, including alcohol and drug abuse, developmental disabilities, and/or AIDS/HIV related disorders. This authorization may be revoked in writing at any time, except to the extent that releases have already been made, and will expire without express revocation whenever legal or contractual obligations or the evaluation or treatment at Milwaukee Health Services, Inc. and its Clinics have been completed.

ASSIGNMENT OF BENEFITS

I hereby authorize, request and assign payment directly to Milwaukee Health Services, Inc. and its Clinics by all insurance carriers and Social Security Administrators with whom I have coverage or for who benefits are, or may become, payable to me, including settlements of judgments arising from the incident for which I am receiving treatment. I agree to pay Milwaukee Health Services, Inc. and its Clinics for all charges for services not covered by my insurance plan.

AUTHORIZATION FOR TREATMENT

I hereby authorize treatment for services I will receive at Milwaukee Health Services, Inc. and its Clinics. I understand that this consent is in effect for one year, at which time I will be required to consent to receive future services. I also give Milwaukee Health Services, Inc. permission to review and share with other institutions, agencies and law enforcement my medical records in accordance with HIPPA regulations.

By signing below, I agree to the terms and conditions of this consent, and acknowledge that, if applicable, I am the legal guardian of the above minor child.

I, the undersigned, have read and understand the above information.

_____ _____

Signature of Patient, Parent or Guardian Date

_____

Relationship to Patient

_____

Witness