IDEAL HEALTHCARE SOLUTIONS

Patient Registration Form

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred Method of Contact for reminder calls and other electronically generated messages: (Please Select Only One Option) ☐ Voice ☐ Text			If Voice, Please Select Preferred Number : ☐ Home ☐ Cell ☐ Work
Date of Birth:	Sex: ☐ Male ☐ Female		HCP:
Marital Status:	Social Security #:		
Assisted Living	Emergency Contact Name:		
Emergency Contact Phone #:			Relationship to Patient:

Additional Information and Responsible Party

Responsible Party-

Last Name:	First Name:	
Date of Birth:		Phone:
Address of Person Responsible:		
City/State/Zip:		Relationship to Patient:

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian ☐ Other	
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's ID #:	Policy Holder's ID #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I have read and agree to Ideal Healthcare Solutions (IHS)payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to IHS all money to which I am entitled for medical expenses related to the services performed from time to time by IHS, but not to exceed my indebtedness to IHS. I authorize IHS to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $15.00 returned check fee will be charged for checks returned due to insufficient funds. By choosing text messaging and/or email as a communication method, I acknowledge that Ideal Healthcare Solutions is not liable for any wireless charges I may incur and that unencrypted patient information may be sent to me via text message or email. MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to IHS. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Ideal Healthcare Solution's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: X _____ **Date:**

Printed Name of Responsible Party: X _____ **Date:**