SUGARS LOVING MEMORIES PERSONAL CARE LLC.

8531 W LISBON AVE.
MILWAUKEE, WI 53222
PH:414-732-9999
FAX:262-661-7491

PATIENT REGISTRATION FORM

**Today's Date: ________________________

PATIENT INFORMATION: (Please use full legal name, no nicknames)

*Last Name: _____________________________________ *First Name: ___________________________________ Middle Initial: ____________

*Address:
____

City: ____ State: ____________________________ Zip: ___________

Home Phone #: (________) ________-________ *Social Security #: _______________

*Date of Birth: _________ Age: _________ *Sex: _______ Marital Status: ____________ Drivers Lic#: ______________

*Employer Name and Address:
____

Work Phone #: (________) ____________-_____________

E-mail Address: ____Cell Phone #: (____) ____ -_____

Emergency Contact Name: _________________________________ Emerg Phone #: (____) ____-_______

Please tell us how you heard about us: _____________________________Referred by____________________

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

*Relationship of Guarantor to Patient: Self _____ Spouse _____ Parent ______ Other _____________________________

*Last Name: ___________________________________ *First Name: ___________________________________ Middle Initial: _____________

*Address:
____

City: __________________ State: _________________Zip: _______________

Home Phone #: (_______) _______-___________*Social Security #: __________________________

*Date of Birth: ________________ Age: ____________________ *Sex: Female _______ Male ________

*Employer Name and Address:
____

Work Phone #: (____)____-_______

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards on first Appointment)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS
PRIMARY INSURANCE: Plan Name : ____ *Insured's Name: ___________________________________

Insured's Social Security #: _____________________*Insured's Date of Birth: _____________________ *Policy / ID #: _________________________ *Group #: _____________________ Eff Date: _____________

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Claims Address & Phone: ____

SECONDARY INSURANCE: Plan Name : _____________________

*Insured's Name: ______________________

*Insured's Social Security #: __________________*Insured's Date of Birth: ___________________

*Policy / ID #: ________________ *Group #: ________________________ * Eff Date: ___________________

Claims Address & Phone:
____

*REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS.

Please read and sign back of form.

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PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

Patient Name: _______________________ Date of Birth: _________________

First Name________________________ M.I._____Last Name___________________

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of my insurance benefits to SUGARS LOVING MEMORIES PERSONAL CARE LLC., for services rendered to my dependents or me by the staff or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that SUGARS LOVING MEMORIES PERSONAL CARE LLC., is unable to collect from my insurance carrier for whatever reason.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION: I certify that I have received and read a copy of the Patient Information Privacy Policy. I hereby authorize SUGARS LOVING MEMORIES PERSONAL CARE LLC., individually to release any of my or my dependent's medical or incidental non- public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL: I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize SUGARS LOVING MEMORIES PERSONAL CARE LLC., a representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying to that effect in writing to SUGARS LOVING MEMORIES PERSONAL CARE LLC.

CONSENT TO SERVICES: I hereby consent to services as directed by your physician, LLC.,patient or his or her designee.SUGARS LOVING MEMORIES PERSONAL CARE LLC.

PATIENT SIGNATURE: ________________________DATE: ______________________

GUARANTOR SIGNATURE: ____________________________DATE: ______________________

(If different from patient)

GUARANTOR NAME (Please Print):
____