P3 Health Partners

People. Passion. Purpose.

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT	Guarantor Information (to whom statements are sent)
Last Name:	Name:
First Name:	Address:
Middle Name:	
Address:	Relationship to patient: _____
City: State:	Date of Birth:
Zip:	Social Security No.:
Home Phone:	Phone: ( ) _____ - _____
Work Phone:	**Emergency Contact Information**
Mobile Phone:	Name:
Sex:	Relationship:
Date of Birth:	Phone:
Social Security No.:	Mobile Phone:( ) _____ - _____
Patient email:	
Required by government mandate [although you may refuse]:	**Employer information**
Language:	Employer:
Race:	Address:
Ethnicity:	Phone:
Marital Status:	

Other	Pharmacy Information:
Patient Referred by:	Name:
Primary Care Provider:	Crossroads:
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email	Phone:

Primary Insurance Information	Secondary Insurance Information
Insurance Plan Name:	Insurance Plan Name:
Last Name:	Last Name:
First Name:	First Name.:
Middle Name:	Middle Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**	Date of Birth: Sex (please circle): **M** or **F**
Employer Name:	Employer Name:
Patient's relationship to policy holder:	Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

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Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for P3 Health Partners**

Signed_____ **Date:**_____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed_____ **Date:**_____

- **I authorize P3 Health Partners to release medical information required to process my claim**

Signed_____ **Date:**_____

- **I have read and understand the Financial Policy for P3 Health Partners**

Signed_____ **Date:**_____

- **I authorize P3 Health Partners to obtain/have access to my medication history**

Signed_____ **Date:**_____

- **I authorize my provider's office to contact me by mobile phone**

Signed_____ **Date:**_____