Eastport Health Care Inc.
Patient Registration Form
Our Specialty is YOU!

Current Patient Information (Please Print)				
Last Name:		First Name:	Middle Name:	Preferred Name:
Street Address	PO Box		City	State Zip
Home Phone: Primary __Y __N		Cell Phone: Primary __Y __N	Work Phone:	Email: (see below)
Would you like to sign up for our patient portal? ____Yes (please list email above) ____Declined				
Date of Birth:	Marital Status:	Social Security #:	Gender:	Primary Caregiver:
Guarantor Name:		Guarantor Address:		Guarantor Phone:
Relationship to Patient:		Social Security #:	Date of Birth:	
Emergency Contact:		Relationship to Patient:	Home Phone:	Cell Phone:
Medical Insurance Information				
Primary Medical Insurance Name		Policy #	Group#	Employer Name
Policy Holder Name/Address (if other than self)			Policy Holder DOB	Relationship to Policy Holder
Secondary Medical Insurance Name		Policy #	Group#	Employer Name
Policy Holder Name/Address (if other than self)			Policy Holder DOB	Relationship to Policy Holder
Dental Insurance Information				
Primary Dental Insurance Name		Policy #	Group#	Employer Name
Policy Holder Name/Address (if other than self)			Policy Holder DOB	Relationship to Policy Holder
Secondary Dental Insurance Name		Policy #	Group#	Employer Name
Policy Holder Name/Address (if other than self)			Policy Holder DOB	Relationship to Policy Holder

Notice of Privacy Practice, Consent, and Assignment of Benefits	**Payment and No Show Policy**
I hereby assign my insurance benefits to be paid directly to the Provider. I authorize the Provider to release any medical/dental information required to process claims. I authorize my Provider's office to contact me by telephone to remind me of my appointment. I acknowledge that I have reviewed the Consent for Medical and Dental Treatment and the Notice of Privacy Practices. By signing below I acknowlege that I have read and agree to the statements listed above and any questions or concerns I have were addressed. Patient/Parent/Guarantor/Authorized Representative Signature:	Quality Care for our patients is our priority. EHC has developed a Payment Policy and No Show Policy to assist you in understanding your financial obligations and the impact on our practice whan a patient "no-shows". By signing below, I acknowledge that I have reviewed, understand, and agree to adhere to the policies. Patient/Parent/Guarantor/Authorized Rep. Signature:
Date:	Date: