AMERICAN MEDICAL CENTER
PATIENT REGISTRATION FORM

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH

RESIDENTIAL ADDRESS	GENDER: ❒ MALE ❒ FEMALE

MAILING ADDRESS (if different form residential address)	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYMENT STATUS: ❒ EMPLOYED ❒ RETIRED ❒ UNEMPLOYED ❒ STUDENT

EMPLOYER / SCHOOL	MARITAL STATUS:

EMAIL

PRIMARY INSURANCE (SUBSCRIBER) INFORMATION

PATIENT RELATIONSHIP TO SUBSCRIBER: ❒ SELF ❒ SPOUSE ❒ CHILD ❒ OTHER

SUBSCRIBER NAME (PERSON THAT CARRIES INSURANCE)	SUBSCRIBER DATE OF BIRTH

PRIMARY INSURANCE COMPANY	INSURANCE POLICY	GROUP NUMBER

EFFECTIVE DATE	EMPLOYER

HOME PHONE	CELL PHONE	WORK PHONE	MAILING ADDRESS

SECONDARY INSURANCE INFORMATION

PATIENT RELATIONSHIP TO SUBSCRIBER: ❒ SELF ❒ SPOUSE ❒ CHILD ❒ OTHER

SUBSCRIBER NAME (PERSON THAT CARRIES INSURANCE)	SUBSCRIBER DATE OF BIRTH

PRIMARY INSURANCE COMPANY	INSURANC POLICY	GROUP NUMBER

EFFECTIVE DATE	EMPLOYER

HOME PHONE	CELL PHONE	WORK PHONE	MAILING ADDRESS

TERTIARY/OTHER INSURANCE INFORMATION

PATIENT RELATIONSHIP TO SUBSCRIBER: ❒ SELF ❒ SPOUSE ❒ CHILD ❒ OTHER

SUBSCRIBER NAME (PERSON THAT CARRIES INSURANCE)	SUBSCRIBER DATE OF BIRTH

INSURANCE COMPANY	INSURANCE POLICY

GROUP NUMBER	EFFECTIVE DATE	MAILING ADDRESS

RESPONSIBLE PARTY/GUARANTOR: IF PATIENT IS UNDER AGE 18, THE PARENT/GUARDIAN RESPONSIBLE FOR THE PATIENT WILL BE LISTED AS GUARANTOR

PATIENT RELATIONSHIP TO SUBSCRIBER: ❒ SELF ❒ SPOUSE ❒ PARENT/GUARDIAN ❒ OTHER

LAST NAME	FIRST NAME	MI	DATE OF BIRTH

MARITAL STATUS	GENDER: ❒ MALE ❒ FEMALE	EMAIL

HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER

MAILING ADDRESS

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

LAST NAME	FIRST NAME	RELATIONSHIP TO PATIENT

HOME PHONE	CELL PHONE	WORK PHONE	EMAIL

AMERICAN MEDICAL CENTER
PATIENT REGISTRATION FORM

PATIENT AGREEMENT

I hereby authorize American Medical Center and its agents to administer such medical examination, diagnostic procedures and/or treatment that in their judgment, may indicate to be advisable for the patients' well-being. I certify that no guarantee or assurance has been made as to the result that may be obtained.

CONSENT FOR MINOR

I, being the parent/guardian entitled to care, custody, and control of the aforesaid minor, do hereby authorize and direct you to render such treatment of said minor in your judgment. It is understood that the above minor must be accompanied by a parent/guardian or otherwise authorized adult (as indicated on a written acceptable form of authorization) at your clinic for examination or treatment, or both. I understand that the physicians, nurses or administrators may deem it advisable that a parent or guardian or other authorized adult be present with said minor for the purpose of assisting in the diagnosis or treatment. I agree to cooperate by being present with said minor at all times. This consent will be in effect until it is terminated by written notice received by American Medical Center where the original has been filed.

CONSENT FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize American Medical Center to request payment for covered services rendered by my billing agent (insurance or employer) and that payment be made directly to American Medical Center or if necessary to apply to the same for benefits on my behalf. I hereby authorize American Medical Center to give the necessary information from my medical records, including laboratory, radiology and diagnosis for payment purposes to my health insurance carrier or billing agent.

Employers/school representatives have the right to verify dates on work/school excuses.

I certify that I have read the foregoing and I am the patient or authorized patient representative and/or I am duly authorized as the patient's guarantor to execute the above and accept its terms. A copy of the authorization and certification may be used in place of the original and may be revoked by the patient or authorized representative at any time in writing.

FINANCIAL AGREEMENT

I fully understand that I am financially responsible for all co-payments, deductibles and services **not covered** by my insurance carrier. In consideration of any services rendered to me, I agree to pay the amount due to American Medical Center upon check-out and agree to pay any late charges and collection fees as appropriate. If my insurance is not a plan American Medical Center participates in, payment in full is expected at each visit. If I fail to provide American Medical Center with the correct insurance information, or insurance changes within a timely manner, I may be responsible for the balance of any claims no longer covered, due to time filing restrictions.

I understand that I am responsible to complete this registration form with accurate information. I acknowledge that this information will be used by American Medical Center for my identifying privacy and billing purposes. I agree to provide valid photo identification and proof of insurance, if requested.

I understand that if I am unable to keep my appointment, I must give **one day notice** to American Medical Center, otherwise a **$50.00** missed appointment charge will be assessed.

I acknowledge that I have received a copy of American Medical Center's Privacy Practice Policy.

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PATIENT/GUARDIAN SIGNATURE **DATE**

1244 N. MARINE CORPS DRIVE ● TAMUNING, GUAM 96913 ● TEL: (671)647-8262 ● FAX: (671)647-8257