Welcome to the Offices of:

Catherine Kilby MD, LLC | Robert Rossero MD, LLC | MaryMargaret Hillstrand ANP, LLC | Patricia Brown, PA-C
Julie McCormick MD, LLC | Mary DeMers DO, MPH,FACP | Christine Bailes ANP,LLC

(Each provider is a separate entity)

Patient Registration Form *(Please print all information clearly)*

Patient:

Last Name: _____ First Name: _____ MI: _____

DOB: _____ /_____ /_____ SSN: _____ / _____ / _____ Sex: ☐ M ☐ F

Mailing Address: _____

City State Zip

Primary Phone: (____)_____-_____
☐ OK to call, leaving a detailed message
☐ OK to call, leaving message with a call back number only
☐ OK to call, but leave no messages

Work Phone: (____)_____-_____
☐ OK to call, leaving a detailed message
☐ OK to call, leaving message with a call back number only
☐ OK to call, but leave no messages

Other Phone: (____)_____-_____
☐ OK to call, leaving a detailed message
☐ OK to call, leaving message with a call back number only
☐ OK to call, but leave no messages

Who should we contact in the event of an emergency?
Name: _____
Phone(s): _____
Relationship to Patient: _____

May we discuss your condition with a member of your household? ☐ Yes ☐ No
If so, with whom? _____ Relationship to Patient: _____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Prefer not to answer Preferred Language: _____

Race: ☐ Caucasian or European American ☐ African American
☐ Native Alaskan or Native American ☐ Native Hawaiian or other Pacific Islander
☐ Prefer not to answer ☐ Asian or Asian American

Marital Status: ☐ Single ☐ Married ☐ Other: _____

Employment Status: ☐ Full time ☐ Part Time ☐ Student ☐ None

Insurance: (Please present insurance card(s) and photo ID to the front desk for scanning)

Do you have **Primary Insurance**? ☐ Yes ☐ No If Yes: Insurance name _____
Policy Holder: _____ DOB:_____ Relationship to Patient:_____
Policy /Member # _____ Group # _____

Do you have **Secondary Insurance**? ☐ Yes ☐ No If Yes: Insurance name _____
Policy Holder: _____ DOB: _____ Relationship to Patient: _____
Policy /Member # _____ Group # _____

Do you have **Tertiary Insurance**? ☐ Yes ☐ No If Yes: Insurance name _____
Policy Holder: _____ DOB: _____ Relationship to Patient: _____
Policy /Member # _____ Group # _____

Assignment and Release:

I hereby consent to be treated in this office. I hereby authorize my insurance benefits to be paid directly to the Physician. I also authorize the Physician to release any information, including HIV status that is required in the processing of my claims. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. If I have been referred to this office by another physician or I am being referred to another physician, I authorize release of my medical records to that physician. Lab and test fees may be added to my invoice after I have left the office.

Patient Signature (or Responsible Party): _____ Date: _____

Reviewed/ No Changes: _____ Date: _____
Reviewed/ No Changes: _____ Date: _____
Reviewed/ No Changes: _____ Date: _____