Regent Medical
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PATIENT INFORMATION:

FIRST NAME: _____ **LAST NAME:** _____ **MI:** ____
DOB: _____ **SOCIAL SECURITY NUMBER:** _____
ADDRESS: _____ **APT/LOT:** _____
CITY: _____ **STATE:** _____ **ZIP CODE:** _____
E-MAIL: _____ **MARITAL STATUS:** ☐ **SINGLE** ☐ **MARRIED** ☐ **OTHER**
HOME NUMBER: _____ **CELL NUMBER:** _____
EMERGENCY CONTACT: _____ **NUMBER:** _____

RESPONSIBLE PARTY/GUARANTOR:

FIRST NAME: _____ **LAST NAME:** _____ **MI:** ____
DOB: _____ **SOCIAL SECURITY NUMBER:** _____
ADDRESS: _____ **APT/LOT:** _____
CITY: _____ **STATE:** _____ **ZIP CODE:** _____
HOME NUMBER: _____ **CELL NUMBER:** _____

RACE:

☐ White/Caucasian
☐ Black/African American
☐ Asian
☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander
☐ Other
☐ Patient declines to provide

ETHNICITY:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Patient declines to provide

LANGUAGE:

☐ English
☐ Spanish
☐ Other: _____

FINANCIAL AUTHORIZATION:

I authorize Regent Medical to release information regarding my treatment for insurance purposes or at my request. I understand that I am financially responsible for all charges. In the even that payment is not made on this account and it is placed with a licensed collections agency, I agree to pay the fees of the collection agency equal to the maximum of 50% of the outstanding balance at the time the account is placed with the agency. Interest of 10% per year will be accrued on the principal balance placed with the agency. Should legal action also be necessary to collect the account, I agree to pay attorney's fees and court costs incurred for collection. Thank you!

PATIENT PRINTED NAME: _____
RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____
DATE: _____