

Registration & Financial Evaluation Record

Miami Beach Community Health Center

Patient Information						
Medical Record Number Chart Loc.	Last Name		First Name		MI	Date Pt. Became a Pt.
SSN	Birth Date	Race	Sex	Marital Status	Age	Bill Type
Address		Apt#	City, State, Zip			
Home Phone	Work Phone	Work Status	Employer Name		Relationship to Guarantor	
Emp Phone	Ext.	Account Number			Operator Number	

Guarantor Information						
Medical Record Number Chart Loc.	Last Name		First Name		MI	Reg. Date
SSN	Birth Date	Race	Sex	Marital Status	Age	
Address		Apt#	City, State, Zip			
Home Phone	Work Phone	Work Status	Employer Name			
Emp Phone	Ext.	Account Number				

Insurance Information			
Primary Insurance	Plan Name	Plan Number	Insurance Policy Effective and end date
Secondary Insurance	Plan Name	Plan Number	Insurance Policy Effective and end date

THE PRECEDING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Name _____ Date _____ Time _____

TREATMENT/PAYMENT AGREEMENT FOR MIAMI BEACH C.H.C. (SM)
 I request the above to provide me and/or my family with medical care.
 I acknowledge my responsibility to pay for that care according to the fees established. Furthermore, I authorize assignment of benefits for medical/dental services to be paid to MIAMI BEACH C.H.C. (SM).

Signature of PT
