PATIENT REGISTRATION

Patient Information

Patient Name: Last	First	M.I.	Gender: M F
By what name to you preferred to be addressed?	Marital Status:	Race:	Hispanic ☐ Not Hispanic ☐
Mailing Address:			
City:	State:	Zip:	
Home Phone:	Cell Phone:	E-mail Address:	
Social Security #:	Birth date:	Age:	
Employer:	Phone:	Occupation:	
Emergency Contact:	Phone:		

Insurance

Primary Ins. Name:		Secondary Ins Name:	
Guarantor's Name: _____ Policy ID: Group #:	Guarantor's Birth Date: ___/____/____	Guarantor's Name: _____ Policy ID: Group #:	Guarantor's Birth Date: ____/____/____
Employer's Name:		Employer's Name:	

Name of guarantor responsible of paying the bill:	Birth Date _____/___/_____
Address:	Phone:
City: State: Zip:	

Referral

Referred By:

☐ Phone Book yellow pgs ☐ Web search (Google, Yahoo) ☐ Insurance Web Site or Book

☐ Dr. Referral : _____ ☐ Previous patient of this office

☐ Patient of office/Relative: _____ Thank you address:_____

Primary Doctor:_____ Last Seen:_____

Pharmacy Used: _____ Location:_____

Signature

Release of Benefits Information:

I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctors' office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed payment due at time of service)

ALL CO-PAYMENTS DUE ON DAY OF SERVICE.

DO WE HAVE PERMISSION TO: LEAVE A DETAILED MESSAGE ON YOUR ANSWERING MACHINE ☐ YES ☐ NO

LEAVE A BRIEF MESSAGE FOR A CALL BACK WITH ANY MEMBER OF YOUR HOUSEHOLD ☐ YES ☐ NO

LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT ☐ YES ☐ NO

MAY WE DISCUSS YOUR MEDICAL CONDITION WITH A MEMBER OF YOUR HOUSEHOLD ☐ YES ☐ NO

IF YES, WITH WHOM? _____RELATIONSHIP:_____

Patient Signature:_____ **Date:**_____

Parent of Authorized Representative (If applicable) _____