

Patient Registration

(Please Print)

Please present your insurance card at each visit.

PATIENT INFORMATION			
(First Name)	(Middle Initial)	(Last Name)	(Employer Name)
(Street Address)		(Employer Address)	
(City, State)	(Zip Code)	(Employer City, State)	(Zip Code)
(Phone Number)	(Cell Phone Number)	(Employer Phone Number)	
(E-mail Address)	(Date of Birth)	(Primary Physician)	
(Sex) (Marital Status)	(Social Security Number)	(Emergency Contact Name)	
RACE: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black, African American <input type="checkbox"/> Native Hawaiian, Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Declined			
ETHNICITY: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Non-Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Declined			
		LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Chinese <input type="checkbox"/> Other_____	
(Patient's Occupation)		(Emergency Phone Number)	(Relationship to Patient)

GUARANTOR INFORMATION (If guarantor is the same as patient, omit this section.)			
(First Name)	(Middle Initial)	(Last Name)	(Employer Name)
(Street Address)		(Employer Address)	
(City, State)	(Zip Code)	(Employer City, State)	(Zip Code)
(Phone Number)	(Marital Status)	(Employer Phone Number)	
(Social Security Number)	(Date of Birth)	(Cell Phone Number)	

INSURANCE INFORMATION (SUBSCRIBER)

PRIMARY INSURANCE

Address _____ City/State _____ Zip _____

Who holds insurance _____ Birthdate _____

Relationship to Patient _____ Policy # _____ Group # _____

Employer _____ SS# _____ Work Phone _____

SECONDARY INSURANCE

Address _____ City/State _____ Zip _____

Who holds insurance _____ Birthdate _____

Relationship to Patient _____ Policy # _____ Group # _____

Employer _____ SS# _____ Work Phone _____

HOW WERE YOU REFERRED TO US?

(Please check how you were referred to our clinic.)

Insurance Radio Print Ad (newspaper, magazine)

Family/Friend TV Physician _____

Billboard Internet Other _____

ADVANCED DIRECTIVE / LIVING

Would you like information regarding Advanced Directives?

Yes No

Please be advised that we will initiate CPR and dial 911 when a patient is in distress.

CONSENT FOR TREATMENT

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled, including Medicare, private insurance and other health plans, to this practice. I understand it is my responsibility to pay any deductible and/or co-pay amount, and that I am financially responsible for all charges whether or not paid by insurance. I have been informed that some lab studies may go to an outside lab, and I may receive a separate bill for these services. The practice is authorized to use my medical information in its quality assurance and utilization review programs, and may disclose such information for medical research purposes. I understand my photograph may be taken and used for identification purposes only.

Signature _____ Date _____

What is the best phone number to contact you? _____