PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name: _____ First Name: _____ M:___
Address: _____ City: _____
State: ___ Zip: _____ Phone: (_____)_____-_____ Email: _____
Date of Birth: _____/_____/_____ Age: _____ SSN: _____-_____-_____
Ethnicity: Hispanic/Latino or Non Hispanic/Non Latino Language: _____
Race: _____ Sex: M____F____
Preferred Contact Method: _____
How did you hear about us? ☐Mail out ☐ Newspaper ☐ Internet ☐Hospital
☐ Insurance Directory ☐Other: _____

INSURANCE INFORMATION:(ALL information must be completed if applicable)

Primary Ins: _____ Policy #_____ PCP: _____
*Policyholder:_____ *Date of Birth: _____
Other Insurance: _____ Policy #_____

LIST SIBLINGS:_____

_____

PARENT/LEGAL GUARDIAN INFORMATION:

MOTHER'S NAME: _____
Address: _____ City:_____
State: ___ Zip: _____ Home # (_____) _____-_____ Work # (____) _____-_____
Date of Birth: _____/_____/_____ SSN: _____-_____-_____
Employer: _____
Address: _____ City:_____ State:__ Zip:_____

PARENT/LEGAL GUARDIAN INFORMATION:

FATHER'S NAME: _____
Address: _____ City:_____
State: ___ Zip: _____ Home # (_____) _____-_____ Work # (_____) _____-_____
Date of Birth: _____/_____/_____ SSN: _____-_____-_____
Employer: _____
Address: _____ City:_____ State: __ Zip:_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIMS FILED ON MY BEHALF. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN PROVIDING SERVICES.
SIGNATURE: _____ **DATE:** ____/____/____

THIS IS TO CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND I HAVE GIVEN ALL INSURANCE INFORMATION AND I TAKE FULL RESPONSIBILITY FOR ANY CHARGES INCURRED THAT ARE NOT PAID/COVERED BY MY INSURANCE OR THAT ARE RECOUPED DUE TO INSURANCE INFORMATION NOT PROVIDED.
SIGNATURE: _____ **DATE:**____/____/____