Patient Registration Form ~ Please Print

Patient Name: _____ Date of Birth ___ / ___ / ___

Social Security Number: ____ / _____ / ____ Circle One: Male / Female

Mailing Address
Street: _____

City, State *and* Zip Code: _____

Home Phone: (___) _____ - _____ Cell Phone: (___) _____ - _____
May we leave a message? Y N

Email: _____

Referring Physician/Referral Source: _____

Primary Care Physician: _____

Preferred Pharmacy: _____

Who should we contact in the event of an emergency:

Name: _____ Relationship: _____

Home Phone: (___) _____ - _____ Cell Phone: (___) _____ - _____

MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE MEDICAL BOARD OF CALIFORNIA
Our office will bill your insurance. You are responsible for the deductable, share of cost, co-payment at the time of your visit, as well as any costs that may not be covered by your plan. If you do not have insurance, payment is due on the same date of service. Our staff is available if you have any questions.

I authorize payment of medical benefits be made directly to the physician provider for the services rendered. I authorize my doctor to release any medical or other information necessary to process claims with my insurance companies. I request payment of any government benefits to the party who accepts assignment. I authorize use of information from this form to bill my insurance companies.

Signature: _____ Date: _____