PATIENT REGISTRATION

Please Circle One Dr. Lynch Dr. Gulesserian Dr. Gade Dr. Chang Dr. Birnbaum Dr. Sekhon

Patient Information

Patient Name____Sex M F Marital Status M S W D

Address____City_________________________State_________Zip Code______________

Home Phone (_______)_______________________________________Work Phone (________)_____________________________________

Birth Date ___________________Social Security # __________________________________Driver's License ________________________

Employer____Occupation ____

Address____City_______________________State_________Zip Code________________

Your personal email address ____

WHOM MAY WE THANK FOR REFERRING YOU? ____

OTHER FAMILY MEMBER OR FRIEND/OUTSIDE OF HOME

Name ____Phone (_______)__________________________

Address____City_________________________State_________Zip Code______________

Relationship____

Primary Insurance Information

Primary Insurance Company____Phone(_____)________________

Subscriber Name ____

Subscriber Address____City_________________________State_________Zip Code______________

Subscriber Birth Date ____________________Subscriber Social Security # __________________________________

Group # ____Subscriber # _________________________________Eff Date ________________
COMPLETE GROUP # AND SUBSCRIBER # OR ATTACH INSURANCE CARD COPY

Secondary Insurance Information

Secondary Insurance Company____Phone (______)____________

Subscriber Name ____

Subscriber Address____City_________________________State_________Zip Code______________

Subscriber Birth Date ____________________Subscriber Social Security # __________________________________

Group # ___________________________________Subscriber # ________________________________Eff Date _____________________
COMPLETE GROUP # AND SUBSCRIBER # OR ATTACH INSURANCE CARD COPY

IS THIS WORK RELATED? YES / NO (please circle one) **WORK COMP DATE OF INJURY___________________DATE OF ACCIDENT ___________________**

PLEASE PROVIDE THE RECEPTIONIST WITH YOUR INSURANCE CARD(S)
******CO-PAYMENTS MUST BE PAID AT THE TIME OF SERVICE******

I (THE PATIENT) AM HEREBY AUTHORIZING MY HEALTH INSURANCE COMPANY/COMPANIES TO PAY MEDICAL BENEFITS DIRECTLY TO THE ATTENDING PHYSICIAN AND/OR SUPPLIER OF ANY MEDICAL AND /OR SURGICAL SERVICES RENDERED IN ACCORDANCE WITH MY HEALTH INSURANCE POLICY/POLICIES. I AM ALSO AUTHORIZING THE RELEASE OF ANY MEDICAL AND/OR FINANCIAL INFORMATION CONCERNING CARE, TREATMENT, AND CHARGES TO AUTHORIZED PERSONS THAT MAY BE REQUIRED TO COMPLETE CLAIMS PROCESSING. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND/OR ALL COINSURANCE AND/OR DEDUCTIBLES WITHIN 30 DAYS OF RECEIVING A STATEMENT. A PHOTOCOPY OF THE ASSIGNMENT IS TO BE CONSIDERED VALID AS AN ORIGINAL

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PATIENT/RESPONSIBLE PARTY SIGNATURE **DATE**