

REYNOSO MD
Medical Center LLC

Patient Registration

(PLEASE PRINT)

Patient Name _____ Date of Birth _____

Mailing Address _____

City _____ State _____ Zipcode _____

Summer Address _____

Marital Status: Single Married Divorced Separated Widowed Significant Other

Social Security Number _____ Sex: FEMALE MALE

How were you referred to our office? _____

Employer _____ Occupation _____

Pharmacy Name and Phone Number _____

Phone Numbers AND Secure Email Address where you can be **reached** and **to leave** messages:

Home Phone _____ Work Phone _____

Cell Phone _____ Secure Email Address _____

Do you wish to receive e-mails of our newsletter or information related to our practice? Yes No

INSURANCE INFORMATION

(PLEASE PRESENT YOUR INSURANCE CARD TO THE FRONT OFFICE AT EACH VISIT)

Primary Policy Holder Name _____

Primary Policy Holders Date of Birth _____ SSN _____

Primary Insurance Company Name _____

Insurance ID _____ Group # _____

Secondary Policy Company Name _____

Insurance ID _____ Group # _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zipcode _____

Phone Number _____ Cell Number _____

The information above is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any unpaid or nonpaid balances. I authorize REYNOSO MD Medical Center LLC or any billing service and insurance company to release any information needed to process all claims. I am aware of HIPAA policies and Privacy Act of 1974.

Patient/Guardian Signature _____ **Date** _____