

Patient Registration Form

(PLEASE PRINT)

PATIENT INFORMATION

Patient Name
(Last,Middle,First): _____

MailingAddress: _____

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City: _____ State: _____ Zipcode: _____

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Marital Status (circle one): Single Married Divorced Separated Widowed Significant Other

Sex (circle one): FEMALE MALE

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

Phone #1 _____ Phone #2 _____

Cell _____ Secure Email Address _____

Date of Birth: _____ Social Security Number: _____

INSURANCE INFORMATION

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

Primary Policy Holder Name: _____

Primary Policy Holders Date of
Birth: _____

Primary Insurance 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.

Parent/Gaurdian Signature: _____ Date: _____