CHRISTOPHER W. SERRANO, M.D., P.A.

FELLOW, AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY

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BOARD CERTIFIED IN OBSTETRICS AND GYNECOLOGY

PATIENT REGISTRATION

Date:_____

Last name: _____ First name: _____

Date of Birth: _____ SSN: _____

Driver's license: ___ _____ E-mail: _____

Marita status: ____Single ____Married ____Separated ____Divorced ____Widowed

Street address: _____

City, State, Zip: _____

Mailing address: _____

City, State, Zip: _____

Phone #'s: home: _____ work: _____ cell: _____

Employer & address: _____

Name of spouse (if applicable): _____

INSURANCE INFORMATION

Primary insurance: _____

Policy number: _____ Group number: _____

Name of insured: _____ Relationship: _____

Date of Birth of insured: _____ SSN of insured: _____

How did you hear about us? _____

HIPPA

Please name anyone that may call the office on your behalf to receive test results, information, appointments etc. Legally, no one may have access to any of your medical or billing information without your prior consent. Any changes must be submitted in writing.

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____

ASSIGNMENT OF BENEFITS

I give Dr. Christopher Serrano consent for treatment as necessary. I also request that payment from insurance Company be made payable to Dr. Serrano for any services provided by him. I understand that I am financially responsible for any expenses incurred should my insurance fail to pay within a reasonable period of time. I authorize release of any information to my Insurance Company for the purpose of processing my claim. I understand that my records may include information regarding HIV/AIDS testing and substance abuse information. Charges shown by statements are agreed to be correct and reasonable unless appealed in writing 30 days from billing date.

_____ _____

Signature of Patient or Guardian Date