Cogent
Family Healthcare

525 South Drive, Suite 107
Mountain View, CA 94040
Phone: 650-386-0386
Fax: 650-386-0468

PATIENT REGISTRATION FORM

PATIENT NAME _____ **Date** _____

ADDRESS _____ **CITY** _____ **ZIP** _____

PHONE Home: (____)_____ **Work:** (____)_____ **EXT:** ____ **Cell:** (____)_____

EMAIL _____

WIDOWED ___ **MARRIED** ___ **SINGLE** ___ **DIVORCED** ___ **PATIENT'S BIRTHDATE** _____/_____/_____

SOCIAL SECURITY # _____ **SEX M** _____ **F** _____

INSURED'S NAME (Insurance subscriber if other than patient)_____

INSURED'S DATE OF BIRTH _____ **INSURED'S SEX M** _____ **F** _____

INSURED'S ADDRESS _____ **CITY** _____ **ZIP** _____

INSURED'S EMPLOYER _____ **Insured's Work Phone** (____) _____

INSURANCE COMPANY _____

INSURANCE POLICY ID # _____ **POLICY GROUP #** _____

INSURED'S SOCIAL SECURITY # (if different from Policy ID #) _____

EMERGENCY CONTACT _____ **PHONE** (____)_____

**** I allow leaving medical information at the following number** (____)_____

PREFERRED PHARMACY _____

REFERRED BY (optional) _____

I hereby authorize Cogent Family Healthcare to release all requested and necessary information to my insurance company, or to the Health care Financing Administration and its agents, if I am a patient, and to any consulting healthcare provider as needed for my health care or to obtain payment for my health care. I authorize insurance plan benefits to be paid to Dr. Sims for services provided by him and his staff. I agree to be responsible for payment of all charges for services not covered by my insurance plan, including Medicare.

_____ _____

Patient's Signature Parent or Guardian's Signature