**HEALTH CARE - REGISTRATION FORM**

 

(Please Print & Complete All Sections)

Today’s Date \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Auto Accident? 🞎 Yes 🞎 No

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| **PATIENT INFORMATION** |
| Patient’s Last Name First Middle  | Marital Status (Circle One)Single / Mar / Div / Sep / Wild |
| Is this your legal name? If not, what is your legal name?  | Birth Date Sex |
| Street Address City State ZIP Code  | Social Security Preferred Phone No. |
| Occupation Employer | Employer Phone No. |
| How did you hear about us? (Please check one Box) 🞎 Ins Plan 🞎 Family/Friend 🞎 Returning Patient🞎 Internet Search (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May we contact you via email? 🞎 Yes 🞎 No If yes, email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **INSURANCE INFORMATION** |
| Is this patient covered by Insurance? 🞎 Yes 🞎 No | Name of Primary Insurance |
| Subscriber’s Name | Subscriber’s S.S.# | Birth Date | Group #  | Policy # |
| Patient’s Relationship to Subscriber 🞎 Self 🞎 Spouse 🞎 Child 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name of Secondary Insurance (if application) | Subscriber’s Name | Group | Policy # |
| Person Responsible for Bill Birth DateIs this person a patient her? 🞎 Yes 🞎 No | Address (if different) | Home Phone No. |
| Occupation | Employer  | Employer Address | Employer Phone No. |

Patient’s Relationship to Subscriber 🞎 Self 🞎 Spouse 🞎 Child 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **IN CASE OF EMERGENCY** |

Name of Local Friend or Relative Relationship to Patient Home/Cell Phone No Work Phone No

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The above information is true to the best of my knowledge. I authorize my insurance benefits to paid directly to Soriano Physician Services, PLLC. I understand that I am financially responsible for any balances. I also authorize Soriano Physician Services, PLLC or insurance company to release any information required to process my claims.

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Patient/Guardian Signature Date