**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 Date  Is 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