PATIENT REGISTRATION

Patient's Name _____ Date of Birth _____ Age _____
Last First MI

Address _____
Street City State Zip

Home #_____ Cell # _____ Work # _____ E-Mail _____

Preferred Method of Contact: ☐ Home # ☐ Cell # ☐ E-Mail

Social Security # _____ Marital Status _____ Employer _____ Occupation _____

Address _____
Street City State Zip

REFERRED BY_____

Name of Spouse or Responsible Party_____ Relationship _____Age_____ Date of Birth _____

Address _____
Street City State Zip

Home # _____Cell # _____ Work #_____

Social Security # _____ Employer _____ Occupation _____

Address _____
Street City State Zip

Name of relative NOT living with you _____

Relationship_____ Phone Number_____

Address _____
Street City State Zip

Name of friend NOT living with you_____

Relationship_____ Phone Number_____

Address _____
Street City State Zip

INSURANCE INFORMATION

We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

Name of Primary Insurance Carrier _____ Policy Effective Date_____

Address _____
Street City State Zip

Phone _____ Insured's Name_____ Policy # _____ Group # _____

Secondary Insurance Carrier _____ Policy Effective Date_____

Address _____
Street City State Zip

Phone _____ Insured's Name_____ Policy # _____ Group # _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I Hereby authorize release of any medical information necessary to process any insurance claims with my insurance company and assign benefits otherwise payable to me to the physician or group indicated on the claim. I understand that I am responsible for any deductibles, co-insurance/or amounts for services not covered by the insurance carrier. All professional services rendered are charged to the patient. I further authorize release of all pertinent medical records to my physician at Desert Perinatal Associates for continuing medical treatment.

The patient is responsible for all fees regardless of insurance coverage. In the event of collection proceeding due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to the physician. A copy of signature is as valid as the original.

_____
Signature of Patient or Responsible Party (if minor)

_____
Print Patient Name Date

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Summerlin Location: 10105 Banburry Cross, #430 • Las Vegas, Nevada 89144
Green Valley Location: 3001 Horizon Ridge Parkway • Henderson, Nevada 89052
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