PATEL, PULLIAM & HUBLI

PATIENT REGISTRATION

Name:

Home Address:

E mail: _____

Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian

☐ Other: _____

Sex: DOB:

Ethnicity: ☐ Latino/Hispanic ☐ Other _____

Marital Status:

(Check one): ☐ Employed ☐ Retired ☐ Full time student

☐ Other: _____

Employer:

Employer address:

☐ Cell phone:

☐ Home phone:

☐ Work phone:

Which phone do you want us to call first: ☐ X it

INSURANCE INFORMATION:

PLEASE PROVIDE YOUR INSURANCE CARD INFORMATION

Insurance company**:** **Insurance ID #**

Insurance Address**:**

Insured / Card holder's Name:

Relationship: _____

Group #: Start Date: Phone:

SECONDARY INSURANCE INFORMATION:

Insurance company:

Insured / Card holder's Name: Relationship:_____

Policy # Group #: Phone:

EMERGENCY CONTACT:

First name:_____ Last Name:_____

Cell phone: (_____) _____- _____ Home phone: (_____) _____- _____

Relationship:_____ Work phone: (_____) _____- _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

_____

SIGNATURE (Patient or Parent if Minor)

DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____

SIGNATURE DATE

Reason for appointment: