M.Chávez MD, SC
PROCEDURAL MEDICINE • AUTHENTIC CARE

New Patient Registration Form

PATIENT INFORMATION:

Last Name **First Name** **M.I.** **Date of Birth**

Street Address **Apartment** **City** **State** **Zip Code**

☐Male ☐Female _____ ☐Single ☐Married ☐Divorced ☐Widowed
Social Security Number

Ethnicity: ☐Hispanic ☐Non-Hispanic _____ _____
Race Preferred Language

Area Code Home Phone Area Code Mobile Phone Email address (required)

Preferred Method of Communication: ☐Home Phone ☐Mobile Phone ☐Email

EMPLOYER INFORMATION:

Employer Phone

Street Address City State Zip Code

EMERGENCY CONTACT:

Name Relationship Phone

AUTHORIZATION AND RELEASE:

I authorize the release of any information, including the diagnosis and the records for any treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services; I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE OF PATIENT or Parent (if Minor) **Date**

1509 N. Western Ave. Unit - A, Chicago, IL 60622; Phone: (773) 227-3303; Fax: (773) 897-5848
info@mchavezmd.com