Thomas H. Reece, DO, ND

PATIENT REGISTRATION FORM

Date of your first APPOINTMENT: _____ TIME: _____

Your appointment is scheduled with: _____

PATIENT INFORMATION

(Please complete this entire two-sided form and BRING IT WITH YOU.)

Patient Name _____

Parent or Guardian (if patient is a minor) _____

Address _____

City _____ State _____ Zip _____

Home Tel _____ Work Tel _____

Fax _____ Email address _____

Would you like to receive our emails? Yes _____ No _____

Date of Birth _____ Sex: M _____ F ____ Age _____

Marital Status _____ Driver's Lic# _____

Current HEALTH INSURANCE Carrier _____

Insured's Name _____ Relationship _____

Employer's Name _____ Insured's Birth Date: _____

Employer's Address _____

_____

Spouse's Name _____ Work Tel _____

Spouse's Employer/Address _____

Who is your current health practitioner or primary provider? _____

Are you seeing another practitioner at PMCM? If so, who? _____

Who referred you to PMCM? (Name) _____

Address and Telephone _____

Nearest Relative/Friend/Emergency Name & Tel _____

_____

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PATIENT REGISTRATION FORM

Patient Registration Form (Continued)

I the undersigned, am financially responsible for all services provided to me at PMCM, and hereby agree that in the event of the default in the payment of any amount due, and if the account should be placed in the hands of an agency or attorney for collections or legal action, I agree to pay additional charges equal to cost of collections. These additional charges may also include agency and attorney fees as well as court costs incurred and permitted by the laws governing these transactions.

_____

Patient Signature

_____

Date

_____

Parent/Guardian Signature (for minor patient)

_____

Date

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all medical benefits to which I am entitled, from my insurance or any other health plan, to:

Thomas H. Reece, DO, ND

25 Mitchell Blvd. #8, San Rafael, CA 94903

Tel: 415-472-2343 Fax: 415-472-7636

Tax ID# 55-084-9641

Signature: _____ Date_____

Name (Printed) _____

**************PAYMENT IS DUE AT THE TIME OF SERVICE***************