Patient Registration

Last Name: _____

First Name: _____

Middle Name + Suffix: _____

Sex: _____ Date of Birth: _____

SSN: _____

Address: _____

City: _____ State _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Consent to call: YES or NO
(artificial, prerecorded, or automated calls and text messages including ReminderCall, GroupCall, ResultsCall, and SelfCall services)

E-Mail: _____

Contact Preference: Hm Wk Cell Email Mail

Marital Status: _____

Language: _____

Race: _____ Ethnicity _____

How did you hear about us? _____

Referring Physician: _____

Primary Care Physician: _____

Is this work or auto related? Yes/No

Emergency Contact Information:

Name: _____

Relation: _____

Phone: _____ Mobile: _____

Next of Kin: _____

Relation: _____

Phone: _____

Guarantor Information

Guarantor Name: _____

Guarantor's relation to patient: _____

Guarantor's Address _____

Primary Insurance Information:

Type of Insurance: _____

Policy holder Name: _____

Relation to Patient: _____

Sex: ____ Date of Birth: _____

Social Security Number: _____

Policy ID Number: _____

Policy Group Number: _____

Employer Name: _____

Employer Phone: _____

Secondary Insurance Information:

Type of Insurance: _____

Policy holder Name: _____

Relation to Patient: _____

Sex: ____ Date of Birth: _____

Social Security Number: _____

Policy ID Number: _____

Policy Group Number: _____

Employer Name: _____

Employer Phone: _____

All fees whether they are covered by insurance or not, are due/payable within 30 days unless other arrangements have been made. A service charge is applicable after this period, regardless of insurance status. It could be either 1 1/2 % per month (18%) annual percentage rate, or a minimum charge of $.50 cents. I hereby authorize my insurance benefits to be paid to the physician. I am financially responsible for all non-covered charges. I authorize the physician to release any information required by other physicians/agencies for the purpose of reimbursement to my account or pending treatment deemed necessary by my physician.

Signature: _____ **Date:** _____

131 Raley Blvd, Chico CA 95928 P (530) 897-4500 F (530) 897-4544