# REGISTRATION FORM

**(PLEASE PRINT)** **Today's Date: _______________**

**√ WHICH DOCTOR YOU WILL BE SEEING TODAY**

_______ Mark C. Chien, M.D., LLC.
_______ Andrew B. Repasy, M.D., S.C.
_______ James H. Sipkins, M.D., S.C.
_______ Noel A. DeBacker, M.D., S.C.
_______ Charles D. Dillon, M.D./Univ .Assoc. In Int. Med., S.C.
_______ Michael A. Ruchim, M.D.

## PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ Other__________ Referred to us by______________________________

LAST NAME______________________________ FIRST______________________________ M.I.__________

ADDRESS______________________________________________ APT__________

CITY______________________________ STATE______________ ZIP______________

PHONES [Home] ( ) ______________ [Work] ( ) ______________ [Cell] ( ) ______________

BIRTH DATE ______________ AGE ________ SOCIAL SECURITY # ______________________

MARITAL STATUS ____ Single ____ Married ____ Div. ____ Sep. ____ Wid. SEX ___ M ___ F

IF MARRIED, SPOUSE'S NAME ______________________________

## EMPLOYMENT INFORMATION

EMPLOYER______________________________ OCCUPATION______________________________

ADDRESS______________________________ CITY______________ STATE________ ZIP________

## INSURANCE INFORMATION

**(Please give your insurance card to the receptionist)**

Is this an accident or injury? **Y N** **Worker's Comp**. File # ______________________

Date of Injury:______________ Authorized by ______________________

______**Auto** ______**Worker's Comp.** Phone (__________)______________________

**PRIMARY**
INSURANCE NAME ______________________________
ADDRESS ______________________________
______________________________

GROUP/POLICY # ______________________________
ID # ______________________________

INSURED ______________________________
(Name on I.D. Card)
RELATIONSHIP TO PATIENT
☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

**SECONDARY**
INSURANCE NAME ______________________________
ADDRESS ______________________________
______________________________

GROUP/POLICY# ______________________________
ID # ______________________________

INSURED ______________________________
(Name on I.D. Card)
RELATIONSHIP TO PATIENT
☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

## INSURED PARTY INFO

**(If other than patient)** (√ ) _____PRIMARY ____SECONDARY

Name ______________________________
Address ______________________________
City ______________ State ________ Zip ______________
Phones Home : ( ) ______________
Work: ( ) ______________

SOC. SEC. # ______________________________
DATE OF BIRTH ______________________________
EMPLOYER ______________________________
Address ______________________________
City ______________ State ________ Zip ________

## AUTHORIZATIONS

**(Please circle Yes or No, and Sign)**

1. Yes No↓ **CONSENT:** (see Privacy Officer) I consent to the use and disclosure of health information required for treatment, payment or healthcare operations.
2. Yes No **ASSIGNMENT OF BENEFITS:** I hereby authorize and request that payment of any insurance benefits be made directly to the aforementioned physician (when assignment is accepted) for medical services rendered. A copy of this authorization is valid as the original.
3. Yes No **RESPONSIBILITY STATEMENT:** I understand I am financially responsible for any balance not covered by my insurance carrier. I understand I may be requested to pay for any out-of-network benefits at the time of service.

______________________________
(Patient Signature)

PLEASE SEE REVERSE SIDE FOR ADDITIONAL INFORMATION

**If you do not have medical insurance, what method of payment will you be using today?**

**______ CASH ______ CHECK ______CREDIT CARD**

## EMERGENCY CONTACT INFORMATION

**NAME** ____________________ **HOME PHONE** (________)____________________

**ADDRESS** ____________________ **WORK PHONE** (________)____________________

**CITY** ____________________ **STATE** ______ **ZIP** ____________ **CELL PHONE** (________)____________________

**RELATIONSHIP** ____________________

Thank you for choosing our office to receive your medical care.