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.