Registration

Email Address ________________
Cell Phone ________________
Work Phone ________________

Date ________________

Patient Name (Last, First Middle Initial) ____
Street Address ________________________________ **City** __________ **State** __________ **Zip** __________
Sex M F Age __________ **Birthdate (MM/DD/YYYY)** ________________ **Social Security # (last 4)** ____________
Single Married Widowed Separated Divorced
Driver's License # ________________________________
Insured's Name (Last, First) ____ **Relationship to Insured: Self Spouse Child Other**
Condition Related to Illness Employment Auto Other

EMPLOYER	Company Name ____ Occupation ____________________________ Address ____________________________ Phone ______________ City __________ State __________ Zip __________
SPOUSE	Name (Last, First Middle Initial) ____ Birthdate ____________________________ Social Security # ______________ Employer Name ____________________________ Occupation ____________________________ Address ____________________________ Phone ______________ City __________ State __________ Zip __________
PATIENT INSURANCE INFORMATION	Please any and all insurance coverage you or your spouse has applicable in this case. MEDICARE BLUE SHIELD AUTO ACCIDENT MEDICAID MAJOR MEDICAL UNION PLAN BLUE CROSS WORKER'S COMPENSATION OTHER BCBS I.D. # _ _ _ _ _ _ _ _ _ _ MEDICARE/MEDICAID I.D. # _ _ _ _ _ _ _ _ _ _ _ MAJOR MEDICAL OR AUTO INSURANCE Date of Accident ______________ Insurance Company Name ____ Adjuster ____________________________ Claim # ______________ Address/Phone ____ Policy # ____________________________ Effective Date ______________
SPOUSE CO-INSURANCE INFORMATION	MAJOR MEDICAL ONLY Insurance Company Name ____ Address/Phone ____ Policy # ____________________________ Effective Date ______________
MEDICAL & LEGAL INFORMATION	Referred by ______________________________________ Present Complaint ______________________________________ Known Medical Problems ______________________________ Pregnant Yes No Pacemaker Yes No Attorney ____________________________ Address ____________________________ Phone ______________ Family Physician (Name and Phone #) ____ Person to contact in emergency (Name and Phone #) ____
PATIENT AGREEMENT	ASSIGNMENT AND RELEASE I, the undersigned, have insurance coverage with ______________________________________ and assign Name of Insurance Company directly to Dr. Javier V. Suarez all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize this signature on all my insurance submissions. ______________________________________ ______________ Signature of Insured/Guardian Date