



2014 Registration

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ SEX: MALE or FEMALE MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

SOC SEC# \_\_\_\_\_ EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

(different than self)

(different than own phone #)

**INSURANCE INFORMATION**

PRIMARY \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

SUBSCRIBERS NAME \_\_\_\_\_ SOC SEC# \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

SECONDARY \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

SUBSCRIBERS NAME \_\_\_\_\_ SOC \_\_\_\_\_

SEC# \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

E-MAIL \_\_\_\_\_ Preferred Language \_\_\_\_\_

ETHNICITY: (PLEASE CIRCLE ONE) *Latin/Hispanic* *Non-Latin/Hispanic* *Refuse to Report* Race: \_\_\_\_\_

PHARMACY \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

MAIL-AWAY PHARMACY \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

LAB OF CHOICE (CIRCLE ONE) *CLINICAL LAB PARTNERS* *QUEST* *OTHER* \_\_\_\_\_

ARE YOU INTERESTED IN  MEDICALLY ASSISTED WEIGHT LOSS  LASER HAIR REMOVAL  BOTOX/ANTI-AGING TREATMENTS

**BILLING INFORMATION**

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn over to collection for non-payment after 120 days, then the patient is responsible for the bill, the interest, and attorney fees.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician for my charges.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the examination or treatment to insurance company in writing or by fax.

MEDICARE STATEMENT (if applicable): This claim will be submitted to Medicare for you by our office. Medicare may not cover some services, which the patient will be responsible to pay. Such identified services include yearly physicals. In addition, you will be responsible for your yearly Medicare deductible and coinsurance if you do not subscribe to supplemental policy.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_