

REFERRED BY: _____

PRIMARY PHYSICIAN: _____ CITY: _____ PHONE: _____

PATIENT REGISTRATION SHEET

PLEASE PRINT CLEARLY

ALL BLANKS MUST BE COMPLETED

PATIENT FULL LEGAL NAME _____ SEX _____ DOB _____ AGE _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____
(Must be street address)

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE(____) _____ DRIVER'S LIC#/CA ID# _____ SS# _____

MARITAL STATUS : SINGLE () MAR () SEP () DIV () WID ()

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PHONE (____) _____ CELL PHONE (____) _____

.....
RESPONSIBLE PARTY

NAME _____ PATIENT'S RELATIONSHIP _____ PHONE # (____) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER _____ ADDRESS _____

WORK PHONE (____) _____ DRIVER'S LIC/CA ID# _____ SS# _____ DOB _____

.....
EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____ PHONE # (____) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

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INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____ SECONDARY INS CO _____

BILLING ADDRESS _____ BILLING ADDRESS _____

CITY _____ ZIP _____ PHONE # _____ CITY _____ ZIP _____ PHONE # _____

INSURED NAME _____ ID # _____ INSURED NAME _____ ID# _____

GROUP# _____ DOB _____ GROUP # _____ DOB _____

IPA/MED GRP _____ PHONE# _____ IPA/MED GRP _____ PHONE# _____

DO YOU HAVE ANY OTHER INSURANCE? YES NO INITIALS _____

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ASSIGNMENT AND RELEASE

I AUTHORIZE INSURANCE PAYMENT OF MEDICAL BENEFITS BE MADE DIRECTLY TO DR. BRUCE FRIEDMAN FOR SERVICES RENDERED. I UNDERSTAND AND ACCEPT PERSONAL FINANCIAL RESPONSIBILITY FOR PAYMENT OF ANY CHARGES FOR SERVICES NOT COVERED BY MY INSURANCE COMPANY. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY MEDICAL CLAIMS.

DATE

SIGNATURE