Patient Registration Form

*Date*_____

Please fill out completely

•*Patient Information*•

*Name*_____ *Soc. Sec.#*_____

Last Name *First Name* *Initial*

*Address*_____

*City*_____ *State*_____ *Zip*_____

Sex (circle one) M /F Age_____ Birthdate_____ Status*(circle one)* Single Married Widowed Separated Divorced

*Home Phone*_____ *Cell Phone*_____

*Patient Employed by*_____ *Occupation*_____

*Business Address*_____ *Business Phone*_____

*How did you find us?*_____

*In case of emergency who should be notified?*_____ *Phone*_____

•*Assignment and Release*•

I , the undersigned certify that I (or my dependent) have insurance coverage with _____

Name of Insurance Compani(es)

and assign directly to Dr. Perea all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether ot not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature *Relationship to Patient* *Date*

•*Privacy Practices Acknowledgement*•

I have received the Notice of Privacy Practices and I have been provided with an opportunity to review it.

*Signature*_____ *Date*_____