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**_____**--[+4:**_____**]**

PHONES [Home] (**)**_____ **[Work] (** **)**_____ **[Cell] (** **)**_____

BIRTH DATE _____ **AGE** _____ **SOCIAL SECURITY #** _____

MARITAL STATUS ____ **Single** ____ **Married** ____ **Div.** ____ **Sep.** ___ **Wid.** **SEX** ___ **M** ___ **F**

IF MARRIED, SPOUSE'S NAME _____ **YOUR EMAIL ADDRESS** _____

EMPLOYMENT INFORMATION

EMPLOYER_____ **OCCUPATION**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist to swipe in scanner)

Is this an accident or injury? **Y N** **Worker's Comp**. File # _____
Date of Injury:_____ Authorized by _____
_____**Auto** _____**Worker's Comp.** Phone (_____)_____

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** _____

If you do not have medical insurance, what method of payment will you be using today?

√ _____ **CASH** _____ **CHECK** _____**CREDIT CARD**

AUTHORIZATIONS (Please circle Yes or No, and Sign)

1. **Yes No** **CONSENT:** **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. Copies of this authorization are 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)

EMERGENCY CONTACT INFORMATION

NAME _____ **RELATIONSHIP** _____ **HOME PHONE (** **)**_____

ADDRESS _____ **WORK PHONE (** **)**_____

CITY _____ **STATE** _____ **ZIP** _____ **CELL PHONE (** **)**_____

Thank you for choosing our office to receive your medical care.