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. Referred here by____________________ LAST 4 DIGITS OF YOUR SOC. SEC.#_________

LAST NAME____ FIRST________________________ M.I.______ SEX ___ M ___ F

ADDRESS____ APT____________________

CITY____ STATE____________ ZIP_____________--[+4:___________]

PHONES [Home] (_____)______________________ [Work] (_____)__________________________ [Cell] (_____)__________________

BIRTH DATE _________________________ AGE ________ YOUR EMAIL ADDRESS ______________________________________

MARITAL STATUS ___ Single ___Married ___ Div. ___ Sep. ___ Wid. IF MARRIED, SPOUSE'S NAME ______________________

YOUR PREFERRED PHARMACY (NAME)____________________ (ADDRESS) ____

EMPLOYMENT INFORMATION

EMPLOYER____ OCCUPATION_____________________________________

ADDRESS____ CITY_________________ STATE________ ZIP_________

INSURANCE INFORMATION

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

Insured Date of Birth________________
(If other than patient)

Is this an accident or injury? **Y N** **Worker's Comp**. File # ________________________

Date of Injury:__________________ Authorized by ________________________

______**Auto** ______**Worker's Comp.** Phone (____)______________________

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)

By signing below, you indicate your understanding that:

- **Each physician using suite 118 practices independently;**
- **In the occasional absence of your physician, one of the other above-name physicians may temporarily cover for your regular physician;**
- **There is no intent to create, either expressly or by implication, any employer-employee relationship, joint venture, partnership or agency between or among the physicians**

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