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San Francisco, California 94118
415.668.2122

Patient Registration Form

Referring Physician: _____ Primary Care Physician: _____

Patient Information: Email: _____ Male ☐ Female ☐

Name: _____ Date of Birth: _____
First M.I. Last

Address: _____
Street Number Street Name Apt# City State Zip Code

_____ _____ _____
Home Phone # Work Phone # Mobile/Cell #

Social Security #: _____ Driver's License #: _____
Patient ID Number

Patient's Occupation: _____ Employed by: _____

Emergency Contact Information:

Emergency Contact: _____ Relationship to Patient: _____
(Name of local relative or friend)

Emergency Contact Address: _____ Phone #: _____

Insurance information:

Name of Insurance: _____ Insurance Phone #: _____

Name of Subscriber: _____ Relationship to patient: _____

Date of Birth: _____ Subscriber's Employer: _____ Employer Phone #: _____

Subscriber ID#: _____ Group number: _____ Effective date: _____

Assignment of benefits and financial Agreement: I hereby give authorization for payment of insurance benefits to be made directly to the above doctor, for services rendered. I understand that I am financially responsible for ALL CHARGES whether or not they are covered by my insurance. In the event of default, I agree to pay ALL COSTS associated with collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original including life time signature on file for filling medical claims for the above named patient. Provider Release: Our office will be submitting this document including our fee slip to our billing service for the sole intent of processing this claim for reimbursement to the carrier indicated above. Privacy Notice: I hereby acknowledge that I have reviewed a copy of this medical practice's "Notice Of Privacy" in the reception area. **If the patient is under 18 years of age, state name of parent, guardian, or responsible party below:**

_____ _____ _____
Date Patient's signature Responsible Party's signature