

PATIENT REGISTRATION - Please print clearly

PATIENT NAME First	Middle	Last	DATE OF BIRTH		AGE
HOME ADDRESS	APT. NO.		CITY	STATE	ZIP
PATIENT'S E-MAIL	SOCIAL SECURITY NO		HOME PHONE	CELLULAR PHONE	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER	GENDER <input type="checkbox"/> F <input type="checkbox"/> M	OCCUPATION	WORK PHONE		
IN CASE OF EMERGENCY, CONTACT		RELATIONSHIP	HOME PHONE	CELLPHONE	
REFERRING PHYSICIAN		REFERRING PHYSICIAN ADDRESS	TELEPHONE		

HOW DID YOU HEAR ABOUT US?

<input type="checkbox"/> FRIEND / FAMILY	<input type="checkbox"/> DOCTOR	<input type="checkbox"/> RADIO <input type="checkbox"/> El Zol <input type="checkbox"/> Viva 900 <input type="checkbox"/> Otra _____	<input type="checkbox"/> YELLOW BOOK
Name _____	Name _____	<input type="checkbox"/> INTERNET <input type="checkbox"/> Google <input type="checkbox"/> Facebook <input type="checkbox"/> My Space <input type="checkbox"/> Other _____	<input type="checkbox"/> OTHER Which one? _____
<input type="checkbox"/> NEWSPAPER	<input type="checkbox"/> TV		
<input type="checkbox"/> El Tiempo L'afro <input type="checkbox"/> El Gazeta <input type="checkbox"/> Other _____	<input type="checkbox"/> Telemundo <input type="checkbox"/> Univision <input type="checkbox"/> Other _____		

BILLING & INSURANCE INFORMATION

RESPONSIBLE PARTY TO BE BILLED	RELATIONSHIP TO PATIENT
RESPONSIBLE PARTY'S ADDRESS	
RESPONSIBLE PARTY'S EMPLOYER	DAYTIME PHONE
PRIMARY INSURANCE COMPANY NAME AND ADDRESS	EVENING PHONE
	I.D. OR POLICY #
	TELEPHONE NUMBER
	DATE EFFECTIVE
NAME OF POLICY HOLDER	POLICY HOLDER'S DATE OF BIRTH
	DAYTIME PHONE
RELATIONSHIP TO PATIENT	
SECONDARY INSURANCE COMPANY NAME AND ADDRESS	I.D. OR POLICY #
	GROUP #
	TELEPHONE NUMBER
	DATE EFFECTIVE
NAME OF POLICY HOLDER	POLICY HOLDER'S DATE OF BIRTH
	DAYTIME PHONE
	RELATIONSHIP TO PATIENT

- Annual Income:**
- \$0 to \$25,000
 - \$26,000 to \$35,000
 - \$36,000 to \$50,000
 - \$51,000 to \$70,000
 - \$71,000 to \$100,000
 - \$101,000 and up

- Race:**
- White / Caucasian
 - Hispanic / Latin
 - African american
 - Indian american
 - Asian
 - Other

- Education:**
- High school
 - High school graduate
 - Some college
 - Associates degree
 - Bachelor's degree
 - Master's degree
 - Professional degree
 - Doctorate degree

FINANCIAL ASSIGNMENT & AGREEMENT:

1. In order to control your cost of billing, we request that your charges for Offices Visits be paid at the conclusion of each visit unless you are a beneficiary of medicare.
2. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my medical insurance.
3. I authorize the release of any medical information or other information necessary to process insurance claims.
4. I accept responsibility for any legal fees and collection agency charges which may be incurred if I fail to pay any pending balances.

X

PATIENT SIGNATURE _____

PARENT SIGNATURE IF MINOR _____

DATE _____