ARROYO OAKS MEDICAL ASSOCIATES, INC.

CONFIDENTIAL PATIENT REGISTRATION FORM

Name: _____ (Last) _____ (First) Sex: _____ Birth date: _____

Address: _____ City: _____ ST: _____ Zip: _____

Social Security #: _____ Driver's License #: _____

Primary Phone: ( ) Home ( ) Cell (____): _____ Secondary Phone: ( ) Home ( ) Cell (____): _____

Employer: _____ Occupation: _____ Work #: (____) _____ ext _____

Address: _____ City: _____ ST: _____ Zip: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Spouse's Name: _____ Birth date: _____ Referred by: _____

Emergency Contact Name: _____ Relationship: _____ Contact #: (____) _____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____ /Driver's Lic. #: _____ Relationship: _____ DOB: _____

Address: _____ City: _____ ST: _____ Zip: _____ Home #: (____) _____

Employer: _____ Address: _____ Work #: (____) _____ ext _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Group/plan: _____ Policy ID #: _____

Policy Holder's Name: _____ DOB: _____ SS #: _____

Relationship to Patient: _____

Secondary Insurance Company: _____ Group/plan: _____ Policy ID #: _____

Policy Holder's Name: _____ DOB: _____ SS #: _____

Additional information: _____

I hereby authorize my physician and any physicians and/or assistants to whom he/she may designate to render treatment as deemed necessary by my physician.
I hereby authorize Arroyo Oaks Med. Assoc., Inc. to release any and all medical information necessary to process my insurance claims; and, payment of medical and/or surgical benefits directly to Arroyo Oaks Med. Assoc., Inc. This authorization shall be valid until revoked in writing. A photostat of this authorization shall be valid as an original.
I am aware the office policy is to present my insurance card at each visit and this will be the insurance processed for that date of service. Failure tp present my insurance card may jeopardize my benefits and will forfeit any contractual obligation. Arroyo Oaks Med. Assoc., Inc. may have with my insurance, including retroactive billing and negotiated discounts. I am responsible for knowing my plan benefits as well as any restrictions. I understand that I am responsible for any portion of the bill not covered by my insurance and I agree to pay in full at time of service.
I have read and understand all of the above and hereby state the information is correct to the best of my knowledge. My signature indicates that I approve and grant request of the authorizations.

_____ Signature: Patient or Legal Representative

_____ Today's Date

_____ If signed for minor, relationship of guardian