



Please PRINT and complete all sections below

**PATIENT REGISTRATION INFORMATION**

Insurance cards copied <input type="checkbox"/>	Account #:	Insurance:	Copayment: \$
Is patient's condition a result of an auto accident? YES <input type="checkbox"/> NO <input type="checkbox"/> Date of Injury _____			

**PATIENT'S PERSONAL INFORMATION**

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First MI

M or  F Language Spoken:  English  Spanish  Other \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Preferred method of contact:  Cell Phone  Home Phone  Work Phone  E-mail

Cell Phone \_\_\_\_\_ Approval to leave message?  Y  N  
 Home Phone \_\_\_\_\_ Approval to leave message?  Y  N  
 Work Phone \_\_\_\_\_ Approval to leave message?  Y  N  
 E-mail Address \_\_\_\_\_ Approval to leave message?  Y  N

**FINANCIALLY RESPONSIBLE PARTY INFORMATION**

Financially Responsible Party \_\_\_\_\_ Relationship to Patient:  Mother  Father  Other \_\_\_\_\_

Date of Birth \_\_\_\_\_ CA Driver's License \_\_\_\_\_ Social Security # \_\_\_\_\_

Responsible Party's Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ E-mail \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_ Responsible Party's Occupation \_\_\_\_\_

Address \_\_\_\_\_ Suite# \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Preferred method of contact:  Cell  Home  Work Approval to leave message or email?  Y  N

**PATIENT'S INSURANCE INFORMATION AND ELIGIBILITY GUARANTEE**

**Primary Insurance Company Name** \_\_\_\_\_ Subscriber (if other than patient) \_\_\_\_\_

Insured's Relation to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Subscriber S.S. # \_\_\_\_\_

Group # \_\_\_\_\_ Insurance ID# \_\_\_\_\_

Insurance Billing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**Secondary Insurance Company Name** \_\_\_\_\_ Subscriber (if other than patient) \_\_\_\_\_

Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_ Insured's Relation to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Billing Address \_\_\_\_\_ Suite# \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**HMO** **PPO**

Medical Group/IPA \_\_\_\_\_ PCP \_\_\_\_\_ Effective Date \_\_\_\_\_ Copayment \_\_\_\_\_

Effective Date \_\_\_\_\_ Copayment \_\_\_\_\_ Coinsurance amount \_\_\_\_\_ % Deductible \_\_\_\_\_

Eligibility verified  online or  telephone call Deductible amount met \_\_\_\_\_

Name of health plan representative \_\_\_\_\_

I understand that if the information provided above is incorrect or if the patient is not eligible under the stated insurance program or health plan, that I am liable for the charges incurred for services rendered. Additionally, I am liable for charges for services rendered which are considered not medically necessary; are considered cosmetic or not otherwise covered by the stated insurance program or health plan; and services which are not authorized in accordance with my health plan and/or medical group. In such instance, I agree to pay in full for all services rendered and shall do so within thirty days after receipt of invoice from the above-noted medical group or physician.

Signature \_\_\_\_\_ Office Personnel Verifying \_\_\_\_\_ Date \_\_\_\_\_



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## PATIENT REGISTRATION INFORMATION

### PATIENT'S REFERRAL INFORMATION

Referred by: \_\_\_\_\_ If referred by a friend, may we thank her or him?  Yes  No

Name(s) of other physician(s) who care for you: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name of person \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Best number to contact this person \_\_\_\_\_ Alternate phone number \_\_\_\_\_

### MEDICAL CONSENT

The undersigned consents to any x-ray examination, anesthesia, laboratory procedure, medical and surgical treatment or hospital service rendered the patient under the general supervision of, or upon the advice of a physician.

#### Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Caduceus Medical Group and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance carrier. In the event of default, I agree to pay all costs of collection and reasonably attorney's fees in conjunction with such collection efforts. I hereby authorize Caduceus Medical Group and its agents to release all information necessary to secure the payment for services required. I further agree that a photocopy of this agreement shall be as valid as the original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date