Patient Registration Form

1. Patient Information

Name (*Nombre*): _____

Address (*Direcion*): _____ Apt #_____

City (*Cuidad*): _____ State (*Estado*): _____ Zip: _____

Telephone (*Telefono de Casa*): _____ Cell number (*Celular*): _____

Social Security# (*Seguridad Social*): _____-_____-_____

Date of Birth (*Fecha de Nacimento*): _____ Gender: __Male __Female

Marital Status (*Estado Civil*): __ Single __Married __Divorced __Widowed __Other

Referred By (*Referido Por*): _____

Primary Care Doctor (*Doctor Primario*): _____ Last Date Seen: __/__/____

Employer (*Empleador*): _____

E-mail: (*Correo Electronico*): _____

2. Insurance Information

Patient's relationship to insured (*Relacion de Segurado*):

- ❑ SELF
- ❑ SPOUSE Name: _____Date of Birth: _____ SS#: _____
- ❑ CHILD
- ❑ OTHER

Primary Insurance Company Name (*Nombre de Seguro Primario*):_____

Primary Insurance Company Number (*Numero de Seguro Primario*):_____

Are you covered by additional insurance (*Seguro Adicional*):

- ❑ YES
- ❑ NO

Secondary Insurance Company Name (*Nombre de Seguro Secundario*):_____

Secondary Insurance Company Number (*Numero de Seguro Primario*):_____

Other Insurance Company Information: _____

Assignment and Release of Information

I, the undersigned certify that I (or my dependents) have insurance Coverage with the above insurance(s) company and assign directly to Dr. Sandy Amador all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Patient's Signature/ Date