PATIENT REGISTRATION RECORD

Pt. Rec # ____________________

PATIENT'S LAST NAME, FIRST NAME, MI (PLEASE PRINT)	MARITAL STATUS				SEX		BIRTH DATE (MM/DD/YY)	AGE	RELIGION (OPTIONAL)
	S	M	W	D	M	F			

STREE ADDRESS PERMANENT TEMPORARY	CITY AND STATE	ZIP CODE	HOME PHONE#

EMAIL	CELL PHONE #

DRUG ALLERGIES IF ANY	SOCIAL SEC #

SPOUSE OR PARENTS NAME	NO. OF CHILDREN	PREFERRED COMMUNICATION METHOD			
		PHONE	EMAIL	MAIL	TEXT

INSURANCE VERIFICATION		
HMO INSURANCE		
ADOC	FAMILY CHOICE	REGAL MEDICAL GROUP
AFFILIATED PHYSICIANS	CAL POTIMA	SEOUL MEDICAL GROUP
AWVI	MONARCH MEDICAL GROUP	PROSPECT MEDICAL GROUP
DOCTOR'S CHOICE	OTHER	
PPO INSURANCE		
ANTHEM BLUE CROSS	AETNA	BLUE SHIELD
CIGNA	HEALTH NET (COVERED CA)	NIPPON
GEHA	OTHER	
MEDICARE		
MEDICARE	HMO	PPO
MEDICAL		
CAL POTIMA	FAMILY PACT	
OTHER		
TRICARE		
PATIENT NAME:		
PATIENT TYPE: NEW PATIENT / ESTABLISHED PATIENT / RETURNED PATIENT		
CONTACT INFORMATION (CELL/HOME/WORK/OTHER)**:**		
INSURANCE ID NO.:		
DO YOU HAVE AUTHORIZATION / REFERRAL FROM PCP? YES / NO (If YES, PLEASE BRING THE AUTHORIZATION / REFERRAL)		
MEDICATION LIST:		
REASON TO VISIT:		

PERSON TO CONTACT IN CASE OF EMERGENCY	RELATIONSHIP TO PATIENT	HOME PHONE #	WORK PHONE #
HAS ANY OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN BEFORE?			
REFERRED BY	YOUR FAMILY DOCTOR		OFFICE PHONE #
PHARMACY NAME	PHARMACY FAX #		PHARMACY PHONE #

I authorize the release on any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed ______________________________ Date ______________________________