

Patient Registration

Registration Information

Patient's Name _____ Social Security #: _____
Date of Birth _____ Age _____
Home Address _____
City _____ ZIP _____
Occupation _____ Drivers License# _____
Employer _____ Address _____
Partner's Name _____ Social Security # _____
Date of Birth _____ Partner's Employer _____ Occupation _____
Employer Address _____

Contact Information

OK to leave message at below Number?

Home Phone _____	Y	N
Work Phone _____	Y	N
Cell Phone _____	Y	N
Partner Cell Phone _____	Y	N

Patient Email Address _____

Emergency contact

(Please remember, email messages are sent via internet and cannot be guaranteed to be secure)

Insurance Information

Primary Insurance Company _____ Subscriber _____
Group # _____ Policy # _____
Customer Service Phone # _____
Partners Insurance _____ Are you covered on this plan as well Yes/No
Group # _____ Policy # _____
Customer Service Phone # _____

Referral Information

Where did you hear about our office? _____
Referring Physician _____
Other Physician that recommended SDFC? _____
What caused you to seek services at SDFC? _____

Authorization

I understand that I am financially responsible for all charges, whether or not covered by my insurance company.

Assignment

I permit payment directly to the Center for any benefits due for service rendered.

Medical Records:

Authorization of records is hereby granted for the purpose of treatment, payment or health care operations in relation to the services provided at SDFC.

Other specific request to release your medical records must be made in writing and maintained on file at SDFC. SDFC has posted a copy of their Privacy Standards, a copy is provided upon request.

Signature _____ Date _____