

PATIENT REGISTRATION

- Please Print-

Today's Date: _____ Please circle- Male / Female

First Name _____ Last name _____ Middle Initial _____

Home address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Date of Birth _____ Social Security # _____

Email address: _____ Can we contact you via email? _____

Currently Employed Yes__ No__ Retired__ Occupation: _____

Employer's Name _____ Position: _____

Pharmacy name and location _____

Marital Status- Single ___ Married ___ Divorced ___ Widowed ___

Primary language _____

Race -check one- Caucasian ___ African American ___ Asian ___

Native Hawaiian /Pacific Islander ___ American Indian /Alaska Native ___

Undefined/ Unknown ___ Other _____

Ethnicity -check one- Hispanic or Latino ___ Not Hispanic or Latino ___

Emergency Contact Person: _____

Home Phone _____ Cell Phone _____ Relationship _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company _____

Policy#: _____ Group#: _____

Policy Holder Name _____ Date of birth _____ SS# _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company _____

Policy#: _____ Group#: _____

Policy Holder Name _____ Date of birth _____ SS# _____

ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby assign all medical and/or surgical benefits, to which I am entitled to Jay Y PARK MD PC. This assignment remains in effect until revoked by me in writing. A facsimile or photocopy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. I consent to the release of information by JAY Y PARK MD PC and my health insurance and/or payor to JAY Y PARK MD PC, and its employees/ representatives to facilitate peer review and of my treatment including utilization and quality management. I understand that Jay Y PARK MD PC will maintain the confidentiality of this information at all times. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that my medical insurance is a contract between myself and the insurance company and/ or my employer. JAY Y PARK MD PC is not party to said contract. I understand that I am responsible for legal and/or collection fees necessary to settle my account, should it become delinquent.

Signature of Patient (or Guardian)

Date
