CARRERAS MEDICAL CENTER
whole health solutions

PATIENT REGISTRATION FORM

Please know we request that you update this form annually

PATIENT INFORMATION: DATE _____ /_____ /_____

NAME: LAST_____ FIRST _____ MIDDLE INITIAL _____

CIRCLE ONE: MR. MRS. MISS. MS. JR. PREVIOUS NAME: _____ (IF APPLICABLE)

DATE OF BIRTH _____ /_____ /_____ SEX ☐ F ☐ M SOCIAL SECURITY # _____ - _____ - _____

RACE: _____ ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC

MARITAL STATUS: ☐ SINGLE ☐ DIVORCED ☐ PARTNER ☐ WIDOWED

☐ MARRIED, SPOUSE NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP_____ - _____

HOME PHONE _____ - _____ - _____ WORK PHONE _____ - _____ - _____ EXT. _____

CELL PHONE: _____ - _____ - _____

EMAIL _____

EMERGENCY CONTACT:

NAME: LAST_____ FIRST _____

RELATIONSHIP TO PATIENT _____

ADDRESS _____

CITY _____ STATE _____ ZIP_____ - _____

HOME PHONE _____ - _____ - _____ WORK PHONE _____ - _____ - _____ EXT. _____

CELL PHONE: _____ - _____ - _____

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RESPONSIBLE PARTY:(RESPONSIBLE PARTY IS THE PERSON FINANCIALLY RESPONSIBLE FOR THE PATIENT STATEMENT/ BILLS)

ARE YOU THE PRIMARY INSURANCE HOLDER ON YOUR INSURANCE ACCOUNT? ☐ YES ☐ NO

IF NO, COMPLETE BELOW OF PRIMARY INSURANCE HOLDER:

NAME: LAST_____ FIRST _____ MIDDLE INITIAL _____

DATE OF BIRTH _____ /_____ /_____ SEX ☐ F ☐ M SOCIAL SECURITY # _____ - _____ - _____

ADDRESS _____

CITY _____ STATE _____ ZIP_____ - _____

EMPLOYER NAME _____ ADDRESS _____

PHARMACY:

NAME _____

ADDRESS / LOCATION _____

PHONE _____ - _____ - _____

FAX _____ - _____ - _____

Consent to medical treatment: I voluntarily consent to such diagnostic procedures and care deemed necessary by the physician, his or her assistant or designated consultants. I understand the practice of medicine and surgery is not an exact science and I further acknowledge that no guarantees have been made to me as to the result of examination or treatment in this clinic.

Conditions of clinical and financial services: Your insurance will be automatically filed as a courtesy to you. Please verify that your insurance information above is correct. Insurance co-pays and unmet deductibles are due at time of service. I understand and acknowledge that I am liable for all charges designated my responsibility that is not paid by insurance.

Cancellation of Appointments: You must call within 24 hours of your appointment to cancel in order to avoid a cancellation fee of $20. If an emergency arises within the 24 hour period to your appointment, you must also call the office and explain your situation to avoid the cancellation fee.

***Authorization to release information*:** I hereby authorize my provider to release all information pertaining to my treatment to my insurance company or companies and to any other physician or health care provider to whom I may be referred. I hereby authorize regulatory and accrediting agencies to review my medical record during surveys or inspections.

Assignment of benefits: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and other health plans to: **Carreras Medical Center, LLC**

Notice of privacy practices: My signature below acknowledges that I have been given the opportunity to receive a full disclosure of the privacy practices as outlined by the health insurance portability and accountability act of 1996.

PATIENT SIGNATURE _____ DATE _____ /_____ /_____

RESPONSIBLE PARTY SIGNATURE _____ DATE _____ /_____ /_____