South Bay Medical Care, P.C. - Patient Registration Form – Please complete all questions

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____Cell Phone #: _____

DOB: _____ Sex: M F Social Security #: _____ Marital Status: S M W D

Emergency Contact: _____ Phone #: _____ Relationship: _____

Email Address: _____

If the patient is 17 or younger:

I hereby authorize and request medical care for the above patient

Print Name of Parent or Legal Guardian: _____Contact #: _____

SIGNATURE of Parent or Legal Guardian: _____

Insurance & Policy Holders Information

***Who is the Primary Care Physician (PCP)?** _____

Primary Insurance: _____ Policy #: _____ Group #: _____

Policy Holders Name: _____ Policy Holders DOB: _____ SS#: _____
Policy Holders Relationship to patient: ___self ___spouse ___parent

Secondary Insurance: _____ Policy #: _____ Group #: _____

Policy Holders Name: _____ Policy Holders DOB: _____ SS#: _____
Policy Holders Relationship to patient: ___self ___spouse ___parent

Tertiary Insurance: _____ Policy #: _____ Group #: _____

Policy Holders Name: _____ Policy Holders DOB: _____ SS#: _____
Policy Holders Relationship to patient: ___self ___spouse ___parent

Responsible Party

- All charges, including copayments are due at the time of service. The patient/guarantor is responsible for providing accurate information regarding insurance information and patient information for claims to be submitted correctly. Questions concerning eligibility or cost of individual services should be discussed prior to the acceptance of said services.
- I understand my insurance card(s) and photo ID should be present at every visit and will furnish upon request.
- I hereby authorize South Bay Medical Care, P.C. to furnish my insurance company any information necessary to process my claims and hereby assign payment to be made directly to South Bay Medical Care, P.C. I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for any amount not covered by my insurance company and that an interest rate will be compounded on any balance that is sent to a collection agency.
- I have had the opportunity to review and receive the HIPAA Privacy Policy for South Bay Medical Care, P.C. and have signed the authorization form on page 3 of the registration forms.

Date: _____/_____/_____ **SIGNATURE**: _____