

NEW PATIENT REGISTRATION

Date: _____

Social Security Number _____ - _____ - _____

Email Address _____ Pharmacy _____

Patient's Name: _____
Last Name First MI

Date of Birth: _____ Male Female Marital Status: S M W D Age _____

Race: _____ Are you Hispanic? Yes No

Language: _____ Religion: _____ /or Declines to specify

Street Address: _____ City: _____

State/zip code: _____ Home Phone #: (_____) _____ -- _____

Cell Phone #: (_____) _____ -- _____ Driver's License#: _____

Patient's Employer: _____ Work Phone #: (_____) _____ -- _____

Is this work-related? Yes No If yes, date of injury: _____ Claim #: _____

Spouse's Name: _____ SS# _____

PATIENT'S INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

Insurance is through: Patient Spouse Parent Other DOB of Insured: _____

SECONDARY INSURANCE CARRIER: _____

Insurance is through: Patient Spouse Parent Other DOB of Insured: _____

If patient is a Minor, are parents Married, Divorced? Custodial Parent _____

Custodial Parent's Home Phone: (_____) _____ -- _____ Work Phone: (_____) _____ -- _____

Custodial Parent's SS #: _____ Date of Birth: _____

PHYSICIAN INFORMATION

Referring Physician's Name: _____ City: _____

Primary Care Physician: _____ City: _____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact: _____

Phone #: (_____) _____ -- _____ Relationship to Patient: _____

I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.

It is my responsibility to understand and have personally verified if my insurance is contracted with this practice and/or the doctor I am seeing.

I hereby authorize BASS Medical Group to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.

I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.

I also understand, that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to BASS Medical Group. immediately upon receipt.

I, the patient or the patient's representative, understand that all medical doctors at BASS Medical Group are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: www.mbc.ca.gov.

Signature of Patient, Parent or Legal Guardian

Relationship to Patient

Date