



Doctor you are seeing today.

David M. Boland, M.D.	_____	Richard W. Smith, M.D.	_____
David W. Bullis, M.D.	_____	James M. Worthington, M.D.	_____
Jeffrey I. Gassman, M.D.	_____	Christopher M. Chow, P.A.-C	_____
Brad E. Green, D.O.	_____	Nancy Furtado, M.S., P.A.-C	_____
Jerald W. Katz, M.D.	_____	Jason D. Haas, M.S., P.A.-C	_____
Kevin N. Mabie, M.D.	_____	Elizabeth R. Keith, N.P.	_____
George J. Raukar, M.D.	_____		_____

PATIENT REGISTRATION FORM

Date _____

Patient Information

Legal Name _____ <small>Last First M.I.</small>	Sex: M F Age: _____ Birth Date _____
Mailing Address: _____	Residence Address: _____
City / State / Zip: _____	Home Telephone: _____
Social Security Number: _____	Cell Telephone: (_____) _____
Primary care Physician: _____	Referring Physician: _____
Cardiologist: _____	Work Telephone: (_____) _____
Employer: _____	
Employer Address: _____	

Insurance Information

<u>Primary:</u>	<u>Secondary:</u>
Name of Insurance : _____	Name of Insurance : _____
Policy Holder Name: _____	Policy Holder Name: _____
Policy Holder SS#: _____	Policy Holder SS#: _____
Policy Number: _____	Policy Number: _____
Group / Plan Number: _____	Group / Plan Number: _____
Holder's DOB: _____ Sex: M F	Holder's DOB: _____ Sex: M F

Reason for Visit:

(Please be specific as to body part - including left vs. right) _____

Is this due to an injury? Y N Date of Injury: _____

Describe injury: _____

IN CASE OF EMERGENCY, PLEASE GIVE US A TELEPHONE CONTACT THAT IS NOT YOUR PERSONAL RESIDENCE:

Name: _____ Relationship: _____ Telephone: _____

AUTHORIZATION: I hereby authorize the physician to furnish information to insurance carriers concerning this illness/accident and I hereby irrevocably assign the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by insurance. A copy of this authorization shall be considered as valid as the original.

_____ Signature _____ Date