

GRACE SALINAS-GARCIA, MD

REGISTRATION FORM

(Please Print)

Today's date:		PCP:					
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security no.:		Home phone no.: ()		
P.O. Box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
How did you learn about our practice? (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: ()		
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:			Employer phone no.: ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance <input type="checkbox"/> AETNA <input type="checkbox"/> BCBS <input type="checkbox"/> HUMANA <input type="checkbox"/> TRICARE <input type="checkbox"/> UBH <input type="checkbox"/> VALUE OPTION <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> Other							
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other							
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:		
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other							

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Grace Salinas-Garcia, MD or insurance company to release any information required to process my claims.				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	