Rancho Paseo Medical Group
Patient Registration Form

PATIENT INFORMATION

Patient's Last Name, First MI	Marital Status	Date of Birth	Age	Sex

Patient's Address City State Zip	Home Phone No.	Social Security

PERSON RESPONSIBLE FOR EXPENSE (IF PATIENT IS UNDER 18)

Last Name, First MI		
Address	Date of Birth	
City State Zip		
Relationship to Patient	Social Sec. No.	

EMPLOYER

Name		
Address		
City State Zip		
Phone No.	Fax	Mgr.

SPOUSE OF PERSON RESPONSIBLE

Last Name, First MI		
Address	Date of Birth	
City State Zip		
Relationship to Patient	Social Sec. No.	

SPOUSE'S EMPLOYER

Name		
Address		
City State Zip		
Phone No.	Fax	MGR.

NEAREST RELATIVE

Last Name, First MI	Relationship to Pt.	
City State Zip	Phone	

FIRST EMERGENCY CONTACT

Name	Relationship to Pt.	
City State Zip	Phone	

INSURANCE INFORMATION

	Primary	Secondary	FOR OFFICE USE ONLY
Subscriber's Name			
Subscriber's SSN			
Subscriber's DOB			
Subscriber's Emp.			
Relationship to pt.			
Insurance I.D.			

INSURANCE AUTHORIZATION, ASSIGNMENT, AND MEDICAL RECORDS RELEASE AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: "I Authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and it's agents to determine benefits for services provided or benefits for related services. *Special authorization is needed to release any and all information regarding patients that are seen by a Behavioral Health Provider.*

I authorize the following individuals to have full access to my medical information, to receive results on my behalf from Rancho Paseo Medical Group and do authorize this disclosure after being provided any answers to questions regarding my privacy rights.

Names of Authorized Individuals to My Medical Records: _____

Relationship: _____ Date of Birth: _____

ASSIGNMENT OF BENEFITS: I hereby authorize payment of benefits be made directly to Rancho Paseo Medical Group for services provided to me by Rancho Paseo Medical Group. I understand that I am financially responsible to Rancho Paseo Medical Group for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees. I also am aware that I may be charged $10 for missed appointments where I failed to give prior notice or cancellation. This authorization will remain in effect until revoked in writing by the undersigned.

_____	_____	_____	_____
Date	Signature of Patient (If minor, responsible person)	Witness	Date