Patient Registration

Date: _____

Patient Information

First Name: _____ Last Name: _____ Middle Initial:_____

Address:_____ City:_____ State, Zip: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc. Sec.:_____ Drivers Lic: _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: _____

Spouse's Name: _____ Birth Date:_____ Soc Sec: _____

Occupation: _____ Spouse's Employer: _____

Who may we thank for referring you? _____

Phone Numbers

Home: _____ Work: _____ Ext: _____ Cell: _____

E-MAIL: _____

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Pharmacy Name / Pharmacy Phone: _____

Dental Insurance

Name of Insured: _____ Soc. Sec: _____ Birth Date: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Company: _____ Phone Number: _____

Member ID: _____ Group Name: _____Group Number: _____

Is patient covered by additional Insurance: ☐ Yes ☐ No

Name of Insured: _____ Soc. Sec: _____ Birth Date: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Company: _____ Phone Number: _____

Member ID: _____ Group Name: _____Group Number: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my Dependant) have insurance coverage with _____ and assign directly to Dr. Mauricio A. Malo all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Relationship: _____ Date: _____