Daniel Hernandez, M.D / Cynthia Jimmeye, NP



PATIENT REGISTRATION FORM (Please print)

	First Name:					SSN:					
Patient Demographics	Last Name:					Age:	Yrs		Мо		
	Date of Birth:					Sex:	Male -		- Female		
	Home Address					Marital Sta		Single	Married	Widowed	Divorced
	City, State, Zip					Employer:		Single	married	maomea	Bivorceu
	Home Phone:					Occupation	-				
	Cell Phone:					Work Addr	-				
	Email:					Work Phor					
	Email: Emergency Contact					Emergency					
Responsible Party Info (if other than patient)	Name & Relation:					(diff. than					
	First Name:					SSN:					
	Last Name:					Age:	Yrs		Мо		
	Date of Birth:					Sex:	Male		- Female		
	Home Address					Employer:					
	City, State, Zip					Occupation	- 1:				
	Home Phone:					Work Addr	ess:				
	Cell Phone:					Work Phor	ne:				
Insurance Information	Relation to Patient:										
	Primary Insurance Name:					Ins. Card I	Provided:		Yes	No	
	Subscriber Name:						criber ID:				
	Insurance Address:						Group ID:				
	Subscriber DOB:						• Assigned:				
	Secondary Insurance Name:					Ins. Card I	-		Yes	No	
	Subscriber Name:					Subs	criber ID:				
lns	Insurance Address:					(Group ID:				
	Subscriber DOB:					PCP /	Assigned:				
Consent for Treatment	I hereby give consent for medical or surgical treatment to the attending physician to care for myself or I am duly authorized by the patient as his/her general agent to give consent for such treatment. I hereby give consent for release of medical information to consulting physicians and other medical personnel, as may be required in the rendering of treatment, until I revoke this acknowledgment in writing.										
Financial Respons.	I hereby authorize payment directly to the attending physician of any medical/surgical benefits payable to me under the conditions of my policy for services rendered. I hereby give consent for release to authorized person(s) of financial and medical information concerning care, treatments, and charges as may be required to complete all claims for benefits. I understand that I am financially responsible to the above-named office for the services rendered. In the event of collection action, I shall be responsible for any legal fees incurred. I am aware all co-payment amounts are due at the time of visit and must be paid prior to services rendered. I am aware that I am personally responsible for any and all charges for services not covered under my insurance plan, or deductibles/co-insurance amounts that are due prior to active coverage. I understand that I am financially responsible for any and all costs related to laboratory tests, as part of my medical care, that are rendered and not covered by my current insurance plan. I understand a bill will be issued to me for payment on any unpaid/uncovered services.										
Notice of Privacy Practice	By signing this form I acknowledge I have been given the opportunity to read the Notice of Privacy Practices Policy in its entirety, and been offered a copy of the document. Furthermore, I recognize and understand my rights and the ways my protected health information may or may not be used and/or disclosed in relation to my healthcare and services received.										
How did you hear about our office?		Health Fair	Friend or Family	Insurance Assignment	Online Search	Referral		red, who referred by?			
Circle your preferred method of contact		Text	Voicecall	Email	Post Mail						