

Practice Name: Camilla Marquez, M.D.

PATIENT REGISTRATION FORM (Please print)

Patient Demographics section with fields for First Name, Last Name, Date of Birth, Home Address, City, State, Zip, Home Phone, Cell Phone, Email, Emergency Contact Name & Relation, SSN, Age, Sex, Marital Status, Employer, Occupation, Work Address, Work Phone, and Emergency Phone.

Responsible Party Info (if other than patient) section with fields for First Name, Last Name, Date of Birth, Home Address, City, State, Zip, Home Phone, Cell Phone, Relation to Patient, SSN, Age, Sex, Employer, Occupation, Work Address, and Work Phone.

Insurance Information section with fields for Primary Insurance Name, Subscriber Name, Insurance Address, Subscriber DOB, Ins. Card Provided, Subscriber ID, Group ID, PCP Assigned, and Secondary Insurance Name.

Consent for Treatment section with a paragraph of consent text for medical or surgical treatment.

Financial Respons. section with a paragraph of authorization text for payment and consent for release of information.

Notice of Privacy Practice section with a paragraph of acknowledgment text regarding the privacy policy.

Contact information section with a table for 'How did you hear about our office?' and 'Circle your preferred method of contact'.

Patient/Responsible Party Signature

Date