

REGISTRATION / UPDATE

Date: _____ Doctor: _____

Full Legal Name: _____ Other Name(s) Previously Used: _____
 First M.I. Last

Birthdate: _____ Age: _____ Social Security #: _____

Home/Mailing Address: _____ City / State: _____

Zip Code: _____ Home Phone: () _____ Work Phone: () _____

If we have to contact you by phone, how shall we identify ourselves? SDMG Dr's Office Other _____

Best phone number to reach you: _____

Race: _____ Religion: _____ Marital Status: M S W D

Patient's Employer: _____ Occupation: _____

Work Address: _____

Who may we thank for your visit today? _____

INSURANCE INFORMATION

Patient's Insurance: _____ Group / Plan #: _____ Policy #: _____

Insurance Billing Address: _____ Eff. Date: _____

Policyholder's Full Name: _____
 First M.I. Last

Spouse's Insurance: _____ Group / Plan #: _____ Policy #: _____

Insurance Billing Address: _____ Eff. Date: _____

Policyholder's Full Name: _____
 First M.I. Last

ADDITIONAL PATIENT INFORMATION

Spouse or Parent Name: _____ Birthdate: _____ Social Security #: _____

Home Phone: () _____ Occupation: _____ Employer: _____

Work Phone: () _____

In Case of an Emergency, Call: _____ Relationship: _____

Home Phone: () _____ Occupation: _____ Employer: _____

Work Phone: () _____

FINANCIAL AGREEMENT / RELEASE OF INFORMATION: I agree to pay all fees and charges for treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the court determines proper.

The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification. I hereby authorize payment of benefits of my insurance to SAN DIMAS MEDICAL GROUP, INC. I hereby authorize the physician to release any information acquired in the course of my examination or treatment to my insurance company and/or my private physician.

Patient Signature	Date	REVIEWED / INITIALED	REVIEWED / INITIALED
Insured Signature	Date	REVIEWED / INITIALED	REVIEWED / INITIALED