This is a fillable PDF form. For full functionality, please download the form and use **Adobe Acrobat Reader** to complete it, save it, then email it to **staff@epitomedical.com** or simply print it out and complete it by hand. This notice will not print.

EPITOMEDICAL.

George Med-Peds Associates, P.C.
PO Box 82227
Las Vegas, Nevada 89180-2227

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Have you been seen in the clinic in the past three years? ☐ Yes ☐ No Do you have a living will? ☐ Yes ☐ No

Today's Date: _____ Home Phone: _____ Work Phone: _____

Patient Name (Last, Middle, First): _____ Email: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female Race: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other License Number: _____ SSN: _____

Is the patient employed? ☐ Full-time ☐ Part-time ☐ No Is the patient a student? ☐ Full-time ☐ Part-time ☐ No

Patient's Employer or School Name: _____ Occupation: _____

Employer or School Address: _____ Employer or School Phone: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

How did you learn of our practice? _____

TO BE COMPLETED BY RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

Responsible Party Name (Last, Middle, First): _____ Relationship: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female SSN: _____

Employer Name & Address: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____ Insurance Company Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ ID Number: _____

Policy Holder's Name: _____ Policy Holder's Phone: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female SSN: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other License Number: _____

Policy Holder's Employer Name: _____ Employer's Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____ Insurance Company Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ ID Number: _____

Policy Holder's Name: _____ Policy Holder's Phone: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female SSN: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other License Number: _____

Policy Holder's Employer Name: _____ Employer's Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

- I, the undersigned, do hereby authorize my insurance carrier(s) to pay directly to **George Med-Peds Associates, P.C.**, the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any charges not covered by said insurance carrier(s), including co-payments and/or deductible amounts.
- I, the undersigned, to hereby also give my permission to **George Med-Peds Associates, P.C.**, to furnish my insurance carrier(s) any and all information pertaining to my medical records.
- A copy of my signature is valid as the original.

Patient / Authorized Party Name (Printed): _____

Patient / Authorized Party Signature: _____ Date: _____