GEORGE MED-PEDS ASSOCIATES, P.C.
PO BOX 82227
LAS VEGAS, NEVADA 89180-2227

PATIENT REGISTRATION FORM

Have you been seen in the clinic in the past 3 years? ____YES ____NO Do you have a living will? ___YES ___NO

Today's Date: _____ Home Phone: (____)_____ Work Phone: (____)_____

Patient Name (Last name, Middle Name. First Name): _____

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

Date of Birth: _____ Age: _____ Gender: **O** Male **O** Female Social Security number: ____-____-____ Race: _____

Marital Status: O Married O Single O Widowed O Divorced O Other Driver's License Number: _____

Is the patient employed? O Full Time O Part Time O No Is the patient a student? O Full Time O Part Time O No

Patient Employer/School Name: _____ Occupation: _____

Employer/School Address: _____ Employer/School: (____)_____

Emergency Contact Person: _____ 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 to Patient: _____

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

Date of Birth: _____ Age: _____ Gender: **O** Male **O** Female Social Security number: ____-____-____

Home Phone: (____)_____ Work Phone: (____)_____ Driver's License Number: _____

Employer Name/Address: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (____)_____

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

Policy Holder's Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (____)_____

Policy Holder's Date of Birth: _____ Social Security Number: ____-____-____ Driver's License Number: _____

Age: _____ Gender: **O** Male **O** Female Relationship to Patient: O Self O Spouse O Parent O Guardian O Other

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

City: _____ State: _____ Zip: _____ Phone: (____)_____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (____)_____

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

Policy Holder's Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (____)_____

Policy Holder's Date of Birth: _____ Social Security Number: ____-____-____ Driver's License Number: _____

Age: _____ Gender: **O** Male **O** Female Relationship to Patient: O Self O Spouse O Parent O Guardian O Other

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

City: _____ State: _____ Zip: _____ Phone: (____)_____

INSURANCE ASSIGNMENT AND MEDICAL RECORD RELEASE

- 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: _____ DATE: ___/___/____

PATIENT / AUTHORIZED PARTY SIGNATURE: _____ DATE: ___/___/____