HealthCare Partners
A DaVita Medical Group

HealthCare Partners Medical Group

REGISTRATION FORM

PATIENT INFORMATION

Today's Date: | **Doctor:**

Patient's Last Name: | First: | MI: | SSN: | (Office Use) MRN: | ○ New ○ Established

Is this your legal name? ○ Yes ○ No | If not, what is your legal name? | (Former Name): | Birth Date: / / | Age:

Sex: ○ M ○ F | Marital Status | Driver's License Number:

Street Address: | Apt. Number | City: | State: | ZIP Code:

Home Phone: | Mobile Phone: | Work Phone: X | Preference of Contact ○ Home ○ Work ○ Cell

E-mail Address*: | Race: ○ African-American ○ Asian ○ Caucasian ○ Hispanic ○ Other: | Ethnicity: ○ Hispanic, Latin, Spanish ○ Not Hispanic, Latino, Spanish | Primary Language Spoken:

Religious Affiliation (Optional): | Reason for Visit: | Referring Physician: | Primary Care Physician: | How did you hear about our office?:

Have you ever been a patient in any HealthCare Partners Facility Before? ○ Yes ○ No | If yes at which doctor and location

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Home phone : | Alternate Phone: | Relationship to Patient:

EMPLOYMENT

Employer: | Employer Street Address: | Employer City: | State: | Zip:

Employer Phone:

GUARANTOR INFORMATION

Guarantor Last Name: | First: | MI: | SSN: | Home Phone:

Guarantor Address: | Guarantor Employer: | Occupation:

City: State: Zip:

Guarantor Employer Address: | Work Phone:

City: State: Zip:

INSURANCE INFORMATION (PLEASE HAVE THE RECEPTIONIST COPY YOUR INSURANCE CARDS)

Primary Insurance Company: | Insurance Company Phone: | Address:

City: State: Zip:

Subscriber Name: | Subscriber SSN: | Subscriber Birth Date: / / | Policy Number:

Group Number: | Effective Date: / / | Relationship to Patient: | Subscriber Employer:

Secondary Insurance Company: | Insurance Company Phone: | Address:

City: State: Zip:

Subscriber Name: | Subscriber SSN: | Subscriber Birth Date: / / | Policy Number:

Group Number: | Effective Date: / / | Relationship to Patient: | Subscriber Employer:

The above information is complete and correct. I authorize treatment of the above named patient. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor group indicated on the claim. All professional services rendered are charged to the patient. The Patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due the doctor.

A copy of the signature is as valid as the original.

Patient Signature *Date* *Guarantor Signature* *Date* *Registered By:*

*You do not have to supply your email address, but we are collecting this information because HealthCare Partners is working on ways to use the internet to better communicate with our patients. We do not sell or provide our patients' phone numbers, addresses or email addresses to any other organization. Like your medical records, all of the information you supply us is held in the strictest confidence.