

NELSON R MALDONADO, MD REGISTRATION FORM

(Please Print)

Today's date:			PCP:			
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	Social Security no:		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
E-mail address:			Cell phone no: ()		Home phone no.: ()	
Address:		City:		State:	ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()	
Chose clinic because/Referred to clinic by (please check one box): <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital						
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other						
Other Family members seen here:						

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:		Employer:	Employer address:		Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medical <input type="checkbox"/> California Health and Wellness <input type="checkbox"/> Anthem Blue Cross <input type="checkbox"/> Blue Shield						
<input type="checkbox"/> Blue Cross <input type="checkbox"/> Health Net <input type="checkbox"/> Sierra Nevada Medical <input type="checkbox"/> Covered California Blue Cross <input type="checkbox"/> Other:						
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Nelson R Maldonado, MD or insurance company to release any information required to process my claims. If my account is referred to an attorney or collection agency, I will be responsible for all attorney's fees and collection expenses.				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	