

PATIENT REGISTRATION

Please Circle One

Dr. Lynch

Dr. Gulesserian

Patient Information

Patient Name _____ Sex M F Marital Status M S W D
Address _____ City _____ State _____ Zip Code _____
Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____
Birth Date _____ Social Security # _____ Driver's License _____
Employer _____ Occupation _____
Address _____ City _____ State _____ Zip Code _____

EMAIL ADDRESS: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

OTHER FAMILY MEMBER OR FRIEND/OUTSIDE OF HOME

Name _____ Phone (_____) _____
Address _____ City _____ State _____ Zip Code _____
Relationship _____

Primary Insurance Information

Primary Insurance Company _____ Phone (_____) _____
Subscriber Name _____
Subscriber Address _____ City _____ State _____ Zip Code _____
Subscriber Birth Date _____ Subscriber Social Security # _____
Group # _____ Subscriber # _____ Eff Date _____
COMPLETE GROUP # AND SUBSCRIBER # OR ATTACH INSURANCE CARD COPY

Secondary Insurance Information

Secondary Insurance Company _____ Phone (_____) _____
Subscriber Name _____
Subscriber Address _____ City _____ State _____ Zip Code _____
Subscriber Birth Date _____ Subscriber Social Security # _____
Group # _____ Subscriber # _____ Eff Date _____
COMPLETE GROUP # AND SUBSCRIBER # OR ATTACH INSURANCE CARD COPY

IS THIS WORK RELATED? YES / NO (circle one) WORK COMP DATE OF INJURY _____ DATE OF ACCIDENT _____

PLEASE PROVIDE THE RECEPTIONIST WITH YOUR INSURANCE CARD(S)
******CO-PAYMENTS MUST BE PAID AT THE TIME OF SERVICE******

I (THE PATIENT) AM HEREBY AUTHORIZING MY HEALTH INSURANCE COMPANY/COMPANIES TO PAY MEDICAL BENEFITS DIRECTLY TO THE ATTENDING PHYSICIAN AND/OR SUPPLIER OF ANY MEDICAL AND /OR SURGICAL SERVICES RENDERED IN ACCORDANCE WITH MY HEALTH INSURANCE POLICY/POLICIES. I AM ALSO AUTHORIZING THE RELEASE OF ANY MEDICAL AND/OR FINANCIAL INFORMATION CONCERNING CARE, TREATMENT, AND CHARGES TO AUTHORIZED PERSONS THAT MAY BE REQUIRED TO COMPLETE CLAIMS PROCESSING. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND/OR ALL COINSURANCE AND/OR DEDUCTIBLES WITHIN 30 DAYS OF RECEIVING A STATEMENT. A PHOTOCOPY OF THE ASSIGNMENT IS TO BE CONSIDERED VALID AS AN ORIGINAL

PATIENT/RESPONSIBLE PARTY SIGNATURE

DATE