PATIENT REGISTRATION

Welcome to our office!

- CONFIDENTIAL -

PREMIÈRE MEDICAL GROUP

Darrell Corben, M.D., FACP
INTERNAL MEDICINE
877.845.8959

TODAY'S DATE**:** _____

PATIENT NAME: _____ DOB: _____ SEX: **M** **F**
(LAST, FIRST) (MM/DD/YYYY)

HOME ADDRESS: _____
(No.) (STREET) [APT. #] (CITY/STATE) (ZIP CODE)

OCCUPATION: (PAST *OR* PRESENT) _____ EMPLOYER: _____

SOCIAL SECURITY NUMBER: _____ MARITAL STATUS (CIRCLE): **M S D W** E-MAIL:_____

CONTACT #'S:(H. PHONE)_____ (**CELL**)_____ (W. PH.)_____

SPOUSE NAME: _____ DOB: _____ S.S.N._____

OCCUPATION: _____CONTACT PHONE: (CELL) _____(WORK) _____

EMERGENCY CONTACT: _____ RELATION: _____

HOME ADDRESS: _____ PHONE: _____
(IN CASE OF EMERGENCY – CONTACT ADDRESS, NAME, PHONE)

INSURANCE INFORMATION

NAME OF CARRIER: _____ GROUP # _____CONTACT PHONE:_____

ADDRESS: _____ EFF. DATE _____ EXP. DATE _____

SUBSCRIBER I.D. _____ BENEFIT CODE: _____ OFFICE VISIT CO-PAY: $_____

ADDITIONAL (SECONDARY) INSURANCE

NAME OF CARRIER: _____ GROUP # _____ CONTACT PHONE:_____

ADDRESS: _____ EFF. DATE _____ EXP. DATE _____

SUBSCRIBER I.D. _____ BENEFIT CODE: _____

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE DR. Corben TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSSING APPLICATIONS FOR FINANCIAL BENEFIT. I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT IS CORRECT AND CURRENT. I AUTHORIZE RELEASE OF ALL RECORDS UPON REQUEST. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE VALID AS THE ORIGINAL.

PATIENT NAME (PRINT) _____(SIGN) _____ DATE _____