

# PARAGON PAINCARE

## PATIENT REGISTRATION FORM

Patient Information: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss					<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced							
Last Name:			First Name:			Middle Initial:						
Address:			Apt.		City		State		Zip Code			
Sex: <input type="checkbox"/> M <input type="checkbox"/> F			Date of Birth: ____ / ____ / ____			SS#: _____			Phone: (____) _____			
Employer's Name:					Address:							
Employer's Phone Number:					Occupation:							
Emergency Contact:					Relationship:					Phone: (____) _____		
Nearest Living Relative (Not Living With You) :								Relationship: _____				
Name:			Address:			Phone: (____) _____						
Primary Insurance: _____					Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child							
Group Number: _____					Policy Subscriber ID Number: _____							
**** If you, the patient, are not the insured please provide the following information ****												
Name of Insured: (First) _____ (Middle Initial) _____ (Last Name) _____												
Address: _____ City: _____ State: _____ Zip: _____												
Date of Birth: ____ / ____ / ____			Social Security Number: _____						<input type="checkbox"/> M <input type="checkbox"/> F			
Employer's Name: _____					Address: _____			Phone: (____) _____				
Secondary Insurance: _____					Policy Number: _____							
Name of Insured: _____					Date of Birth: ____ / ____ / ____			Sex: <input type="checkbox"/> M <input type="checkbox"/> F				

I request that payment of authorized insurance benefits be made to the physician/supplier for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the insurance carrier and/or its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If at the time of service, I state I have valid insurance coverage, but later if it is determined, for whatever reason, I was not covered, I acknowledge and agree that I am responsible for the entire fee. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as co-insurance and the deductible is based upon the charge determination of the Medicare carrier. My signature authorizes release of the information to the insurer or agency shown. I understand that the responsibility of arranging care under a contracted provider or securing authorizations for referrals, tests, labs, etc., lies with the patient.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

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