Saddleback Family & Urgent Care

vituity
At the heart of better care.

SADDLEBACK FAMILY AND URGENT CARE

REGISTRATION FORM

(Please Print)

Today's date:	**Primary Care Physician:**

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status (circle one)** Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**	**Email address:**	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F

Street address:	**Social Security no.:**	**Home phone no.:** ( )

P.O. box:	**City:**	**State:**	**ZIP Code:**

Occupation:	**Employer:**	**Employer phone no.:** ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

GUARANTOR & INSURANCE INFORMATION (*PLEASE GIVE INSURANCE CARD TO RECEPTIONIST*)

Person responsible for bill:	**Birth date:** / /	**Address (if different):**	**Home phone no.:** ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Aetna ❑ Anthem Blue Cross ❑ Blue Shield ❑ CalOptima ❑ Cigna ❑ Healthnet ❑ Humana ❑ Monarch Healthcare ❑ United Healthcare ❑ Other: _____

Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:** / /	**Group no.:**	**Policy no.:**	**Co-payment:** $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative :	**Relationship to patient:**	**Home phone no.:** ( )	**Work phone no.:** ( )

AUTHORIZATION FOR TREATMENT AND ASSIGNEMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION

I certify that the above information is true and I consent to any medical or surgical treatment rendered the patient under the general and special instructions of the provider.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Saddleback Family and Urgent Care Medical Group. I understand that I am financially responsible for any balance, including but not limited to co-pays, deductibles and non-covered services. I also authorize Saddleback Family and Urgent care or insurance company to release any information required to process my claims. I also agree to complete all necessary paperwork in order for my claim to be paid by my insurance company and accept full liability for all charges if payment is not made on behalf of my insurance company.

_____ _____

Patient/Guardian signature ***Date***