Mitchell L. Seitz, M.D.
Patient Registration Form

PERSONAL INFORMATION

PATIENT'S NAME____ ____________________________________

FIRST MIDDLE LAST

PATIENT'S ADDRESS____ _______________

CITY STATE ZIP

PREFERRED PHONE ( ) ________-________ (CELL/HOME/WORK/OTHER __________________)

ALTERNATE PHONE ( ) _______-_________ (CELL/HOME/WORK/OTHER___________________)

EMAIL ADDRESS ____@____________________________

PREFERRED METHOD OF COMMUNICATION: ______ EMAIL _______ TEXT______ PHONE

TYPE OF DETAILED MESSAGES WE MAY LEAVE:

______ RESULTS ______ APPOINTMENT REMINDERS ______ FINANCIALS

GENDER M F

MARITAL STATUS S M W D

DATE OF BIRTH _______/_______/_________

SOC. SEC. NUMBER ________-_______-________

EMERGENCY CONTACT ( ) _______-_______ (CELL/HOME/WORK/OTHER___________________)

NAME AND RELATIONSHIP OF EMERGENCY CONTACT ABOVE:

____

PERSONS WITH WHOM WE MAY DISCUSS YOUR CARE (IF APPLICABLE)

1. _____________________________________ ____

   NAME RELATIONSHIP PHONE

   WE MAY DISCUSS _____RESULTS_____APPOINTMENT REMINDERS _____ FINANCIALS

2. _____________________________________ ____

   NAME RELATIONSHIP PHONE

   WE MAY DISCUSS _____RESULTS_____APPOINTMENT REMINDERS _____ FINANCIALS

INSURANCE INFORMATION

PATIENT NAME ____

DOB _______/_______/_______ WORK PHONE ( ) ________-_______________

EMPLOYER OF PATIENT ____

EMPLOYER ADDRESS____

MARK HERE IF PATIENT IS THE SUBSCRIBER FOR THE INSURANCE POLICY Y N

(IF PATIENT IS THE SUBSCRIBER, SKIP NEXT SECTION)

NAME OF INSURED (IF NOT THE PATIENT)____

INSURED'S RELATIONSHIP TO PATIENT ____

INSURED'S ADDRESS____

INSURED'S PHONE ( ) _________-________________

INSURED'S DATE OF BIRTH_____/____/_______ INSURED'S SOC. SECURITY _______-_____-______

INSURED'S EMPLOYER____

INSURED'S EMPLOYER ADDRESS____

INSURED'S EMPLOYER PHONE NUMBER ( )_________-____________________________________

PLEASE PRESENT INSURANCE CARD AND PHOTO ID

STAFF MEMBER INITIAL IF BOTH CHECKED ________

NOTICES (PLEASE INITIAL EACH)

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS AND REQUEST THAT PAYMENT OF ALL BENEFITS BE MADE TO DR. SEITZ. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. SHOULD THE ACCOUNT BE REFERRED TO AN ATTORNEY OR COLLECTION AGENCY, THE UNDERSIGNED SHALL PAY ACTUAL ATTORNEY'S FEES AND COLLECTION EXPENSES. ALL ACCOUNTS DUE WILL ACCRUE INTEREST AT A RATE OF 18% PER YEAR STARTING 90 DAYS AFTER THE DATE OF SERVICE. DEDUCTIBLES AND COPAYS ARE DUE AT THE TIME OF SERVICE.

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THERE IS A FEE OF $25.00 FOR ANY CANCELLATIONS MADE LESS THAN 24 HRS BEFORE THE APPOINTMENT AND FOR ANY RETURNED CHECKS.

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I HAVE READ THE NOTICE THAT MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE MEDICAL BOARD OF CALIFORNIA. DR. SEITZ'S LICENSE NUMBER IS A61234.

____

I HAVE HAD A CHANCE TO REVIEW THE PRIVACY POLICY OF DR. SEITZ.

____

I UNDERSTAND DR. SEITZ NO LONGER ADMITS PATIENTS TO THE HOSPITAL, AND IF I AM ADMITTED I WILL BE CARED FOR BY A HOSPITAL SPECIALIST.

____

I UNDERSTAND DR SEITZ NO LONGER CARES FOR NURSING HOME PATIENTS, AND MY CARE WILL BE TRANSFERRED TO A NURSING HOME DOCTOR IF I AM ADMITTED TO A NURSING HOME

____

I HAVE HAD A CHANCE TO REVIEW THE DISCLOSURE ON THE PHYSICIAN PAYMENTS SUNSHINE ACT.

____

____	______/______/______
SIGNATURE	DATE
____	_____/______/_______
GUARDIAN SIGNATURE IF MINOR (RELATIONSHIP)	DATE