

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.

THERE IS A FEE OF \$50.00 FOR ANY CANCELLATIONS MADE LESS THAN 24 HRS BEFORE THE APPOINTMENT AND FOR ANY RETURNED CHECKS.

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

SIGNATURE

____/____/____
DATE

GUARDIAN SIGNATURE IF MINOR (RELATIONSHIP)

____/____/____
DATE