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 $25.00 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