



AFFILIATED WITH SANTÉ PHYSICIANS
A MEMBER OF SANTÉ FOUNDATION MEDICAL GROUP & PART OF SANTÉ HEALTH FOUNDATION

PATIENT REGISTRATION

(PLEASE PRINT)

☐ Update

YR.: 20_____

PATIENT INFORMATION	Patient's Name: _____	
	Date of Birth: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	
	Home Address: _____	
	Mailing Address: _____	
	Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____	
	Consent to receive text messages and or messages for appointment reminders: ☐ Yes ☐ No Cell Phone: (____) _____	
	Employer: _____ Occupation: _____	
	Work Address: _____	
	Emergency Contact Name and Telephone Number	
	SPOUSE RESPONSIBLE PARTY INFORMATION	Responsible Party: _____
Address: _____ Home Phone: _____		
Employer: _____ Occupation: _____		
Work Address: _____		
Work Phone: _____ Driver's License No.: _____		
Spouse's Name: _____		
Spouse's Employer: _____ Occupation: _____		
Work Address: _____ Work / Cell Phone: _____		
INSURANCE INFORMATION		Primary Insurance: _____ Subs. Name: _____
		Company: _____ Subs. Date of Birth: _____
	Address: _____ Sub. I.D.# _____	
	Secondary Insurance: _____ Subs. Name: _____	
	Company: _____ Subs. Date of Birth: _____	
	Address: _____ Sub. I.D.# _____	
	Name of Primary Care Physician _____ Name of Pharmacy: _____	
	Please provide the receptionist with your insurance cards.	
	CONSENT	I hereby give consent for medical or surgical treatment to the attending physician to care for myself or I am duly authorized by the patient as his/her general agent to give consent of such treatment. I hereby give consent for release of medical information to consulting physicians and other medical personnel, as may be required in the rendering of treatment. I understand that I am financially responsible to the above named office for the services rendered. In the event of collection action I shall be responsible for any legal fees incurred.
		Patient / Responsible Party Signature _____ DATE _____
ASSIGNMENT	I hereby authorize payment directly to the attending physician of any medical / surgical benefits payable to me under the conditions of my policy for services rendered. I hereby give consent for release to authorized person of financial and medical information concerning care, treatment and charges as may be required to complete all claims for benefits.	
	Patient / Responsible Party Signature _____ DATE _____	
	How were you referred to our office? ☐ Mailer ☐ Brochure ☐ Friend ☐ Phone Book ☐ Insurance ☐ Other	
Whom may we thank for referring? _____		
NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800) 633-3322 www.mbc.ca.gov		