Sophia Center

REGISTRATION INFORMATION

Date_____ (PLEASE PRINT) Home Phone: ( ) _____

Patient:_____ Cell Phone: ( )_____
Last Name First Name Initial

Responsible Party (if a minor):_____

Street Address: _____ Email : _____

City: _____ State: _____ Zip:_____

Sex ☐ M ☐ F Age:_____ Birthdate:_____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for____years

Patient Employer/School:_____

Employer/School Address: _____

Occupation: _____ Employer/School Phone: ( ) _____

Spouse (or responsible party) Employed by:_____

Business Address _____

Occupation _____ Business Phone: ( )_____

Purpose of Visit:_____

Who is responsible for this account?_____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? ☐ No ☐ Yes ▶ If yes,

Name of Primary Insurer_____

Contract # _____ Group #_____ Subscriber #_____

Name of Secondary Insurer (if any) _____

Contract # _____ Group #_____ Subscriber #_____

☐ Medicare ☐ Medicaid Claim ID #_____

If Welfare, your number_____ County of_____

I prefer to ☐ Pay my balance in full at time of service ☐ Pay my balance in full upon receipt of first statement.
☐ Make payment arrangements prior to service being rendered.

In case of emergency, who should be notified? _____ Phone: ( ) _____

Your Drugstore Name: _____ Phone: ( ) _____

How did you learn of our practice?_____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with_____
Name of Insurance Company(ies)

and assign directly to Dr._____all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient