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PATIENT REGISTRATION FORM

Name _____

□ Male □ Female □ Single □ Married □ Widowed □ Divorced

Date of Birth _____ SSN _____

Home Address _____
(If street address different from mailing address, please include both)

City _____ State _____ Zip _____

Home Telephone _____ Cell _____

Occupation _____ Employer _____

Work Address _____

Work Telephone _____ Extension _____

I was referred by _____

Name of Spouse _____ Cell/Wk _____

Person to contact in an emergency _____

Their home/work/cell no. _____

Name of your medical insurance _____*
*We will make a copy of your insurance card and picture ID driver's license/student ID/passport

Do you have MediCal or Medicaid? □ No □ Yes

Please advise us before you see the doctor if your visit is work-related.
Insurance authorization and paperwork from your employer will be required to file a worker's compensation claim.

AUTHORIZATION: I authorize the use and release of my medical information on all my insurance submissions. I understand that I am financially responsible for all non-covered services rendered, excluding service for authorized work-related injuries. I understand that restricted-network insurance plans (Ex. HMO, IPA, EPO) will consider all services rendered here as non-covered unless they have been specifically pre-arranged and authorized in writing. I authorize my insurance carrier(s) to pay my insurance benefits directly to the physician for services rendered to me. I permit a copy of this authorization to be used in place of the original. I authorize my doctor to act as my agent in helping me obtain payment from my insurance carrier(s). I authorize the doctor to examine, diagnose and treat as necessary. Dr. Horowitz's Notice of Privacy Practices has been presented to me. I acknowledge that the Notice is available in the reception area, on the practice website, and by email or paper copy upon request.

PATIENT SIGNATURE _____ DATE _____