ROSSMOOR MEDICAL ASSOCIATES - REGISTRATION FORM

(Please Print)

Today's Date:	Name of Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Sex: ☐ M ☐ F

Social Security Number:	Street Address or PO Box ,City and Zip Code:	Phone (very important): ( )

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Pacific Islander ☐ Other Race

Email Address: Ok to leave message on Message Machine : ☐ Yes ☐ No

PHARMACY INFORMATION

Preferred Local Pharmacy: City: State	Mail Away Pharmacy	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address (if applicable):	Employer phone no. (if applicable): ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	☐ Medicare	☐ Secure Horizons	☐ HealthNet Seniority Plus	☐ Blue Shield	☐ Blue Cross

☐ Aetna	☐ UnitedHealth	☐ CIGNA	☐ Welfare *(Please provide coupon)*	☐ Other

Subscriber's name:	Subscriber's ID no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Rossmoor Medical Associates to release any information required to process my claims.

Patient/Guardian signature *Date*