PALOVERDE HEALTH SERVICES, PLLC PATIENT REGISTRATION FORM

| **Today's Date: | | | | |
|---|--|--|--|--|
| PATIENT INFORMATION: (Please use full legal name, | no nicknames) | | | |
| *Last Name: *First Name: Middle Initial: | | | | |
| *Address: | | | | |
| City: | State: Zip: | | | |
| Home Phone #: () | *Social Security #: | | | |
| Date of Birth: Age: | *Sex: Marital Status: Drivers Lic#: | | | |
| Employer Name and Address: | | | | |
| | Work Phone #: (| | | |
| E-mail Address: | Cell Phone #: () | | | |
| Emergency Contact Name: | Emerg Phone #: () | | | |
| Please tell us how you heard about us: | | | | |
| GUARANTOR INFORMATION: (List person or insured | name responsible for bill - use full legal name, no nicknames) | | | |
| Relationship of Guarantor to Patient: Self | Spouse Parent Other | | | |
| Last Name: *First N | ame: Middle Initial: | | | |
| Address: | | | | |
| City: | State: Zip: | | | |
| Home Phone #: () | *Social Security #: | | | |
| Date of Birth: Age: | *Sex: Female Male | | | |
| Employer Name and Address: | | | | |
| | Work Phone #: (| | | |
| NSURANCE INFORMATION: (Please allow receptionis | t to photocopy your insurance ID cards) | | | |
| TE COME OF THE MILES IN DAMAND TO MAKE THE TO THE | | | | |
| IF SUMEUNE UTHEK THAN PATIENT IS THE INSURED F | PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS | | | |
| PRIMARY INSURANCE: | | | | |
| PRIMARY INSURANCE: | | | | |
| PRIMARY INSURANCE: Plan Name : | *Insured's Name: | | | |
| PRIMARY INSURANCE: Plan Name : Insured's Social Security #: | *Insured's Name: *Insured's Date of Birth: | | | |
| PRIMARY INSURANCE: Plan Name : Insured's Social Security #: *Policy / ID #: *G | *Insured's Name: *Insured's Date of Birth: | | | |
| PRIMARY INSURANCE: Plan Name : Insured's Social Security #: Folicy / ID #:*G | *Insured's Name: *Insured's Date of Birth: roup #: Eff Date: | | | |
| PRIMARY INSURANCE: Plan Name : Insured's Social Security #: Folicy / ID #: Claims Address & Phone: SECONDARY INSURANCE: | *Insured's Name: *Insured's Date of Birth: roup #: Eff Date: | | | |
| PRIMARY INSURANCE: Plan Name : Insured's Social Security #: *Policy / ID #: *G | *Insured's Name: *Insured's Date of Birth: roup #: *Insured's Name: | | | |
| PRIMARY INSURANCE: Plan Name: Insured's Social Security #: *Policy / ID #:*G Claims Address & Phone: SECONDARY INSURANCE: Plan Name: Insured's Social Security #: | *Insured's Name: *Insured's Date of Birth: roup #: Eff Date: *Insured's Name: *Insured's Date of Birth: | | | |
| PRIMARY INSURANCE: Plan Name : Policy / ID #: *G Claims Address & Phone: Plan Name : Insured's Social Security #: Policy / ID #: *G | *Insured's Name: *Insured's Date of Birth: roup #: *Insured's Name: *Insured's Name: | | | |

Confidential Proprietary Information New Patient Form March 2022

PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

| Patient Name: | | | | Date of Birth: |
|---|---|--|--|--|
| | First Name | M.I. | Last Name | |
| | | | | |
| ASSIGNMENT | OF INSURANCE I | BENEFITS: | | |
| rendered to my depo insurance benefits a | endents or me by the physical manner or mot the ser | sician or under his/her | r supervision. I understar are a covered benefit. I u | PLLC or the physician individually for services and that it is my responsibility to know my understand and agree that I will be responsible om my insurance carrier for whatever reason. |
| MEDICARE/M | IEDICAID/INSURA | NCE BENEFITS | S | |
| my dependent's rec | | may request. I hereby | direct that payment of n | correct. I authorize the release of any of my or my or my dependent's authorized benefits be |
| I certify that I have authorize PaloVerd | e Health Services, PLLC | of the PaloVerde Hea or the physician indiv | alth Services, PLC Patier vidually to release any of | RMATION: nt Information Privacy Policy. I hereby my or my dependent's medical or incidental consultation, or the processing of insurance |
| AUTHORIZAT | TION TO MAIL, CA | ALL, OR E-MAII | L : | |
| representative or m things as appointme | y physician to mail, call, | or e-mail me with cor rangements, and labor | mmunications regarding atory results. I understar | uthorize a PaloVerde Health Services, PLLC my healthcare, including but not limited to such and that I have the right to rescind this vriting. |
| LAB/X-RAY/D | IAGNOSTIC SERV | ICES: | | |
| | | | | ner diagnostic services. I further understand that treimbursed by my insurance for whatever |
| CONSENT TO | TREATMENT: | | | |
| I hereby consent to | the evaluation, testing, a | nd treatment as direct | ed by my PaloVerde Hea | alth Services, PLLC physician or his/her designe |
| PATIENT/REP | SONSIBLE PARTY | Y SIGNATURE: | | |
| DATE: | | RE | LATIONSHIP: | |
| | | | | |