REGISTRATION/UPDATE INFORMATION:

Date: ____________________

Patient: ____

Street Address: ____ Apt # __________

City: ____ State: ____________ Zip: ______________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

Social Security #: _______________________ Age ________ Birth date: _____/_____/_____ M F

Single Married Widowed Divorced

Patient Employed By: ______________________________________ Occupation: ____________________

Employer Address: ____ State: ________ Zip: ____________

Spouse (or Guardian) Name: ____

Employed By: ____

Business Address: ____ State: ________ Zip: ____________

PRIMARY INSURANCE CO.: ______________________

ID# ____

Plan or Group# ______________________________

Insured _____________________________________

DOB: ________ Social Security No. _______________

SECONDARY INSURANCE CO.: ______________________

ID# ____

Plan or Group# ______________________________

Insured _____________________________________

DOB: ________ Social Security No. _______________

In Case of Emergency, who should be notified? _________________________ Phone ____________________

Who may we thank for referring you? ____

Who else may we discuss your medical care or appointment time with? ______________________________

Preferred Local Pharmacy Name: _____________________________ Address: ________________________

Pharmacy Phone Number ____________________ Do you utilize a mail order pharmacy? Yes No

Name of mail order pharmacy: ___________________________________ Id #__________________________

PLEASE READ AND SIGN BELOW

I hereby assign all medical and/or surgical benefits to which I am entitled, including private insurance, Medicare and other health plans to Stella Maris Internal Medicine.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges incurred. I hereby authorize said assignee to release all information necessary to secure the payment.

I agree that ultimately I am responsible for any remaining balance that my insurance company does not pay minus any contracted adjustments and/or discounts.

In addition to the foregoing, I hereby authorize the release of my medical information by or between any of my treating physicians and my insurer, HMO, health benefits payer or any other entity (including by not limited to third party administrators, management companies and provider networks) involved in the administration of my health benefits.

Signature: ____ Date: ____________________