DIABETES & THYROID CARE

NEW PATIENT REGISTRATION FORM

A. PATIENT INFORMATION				
Last Name:		**First Name:**		**Middle Initial:**
Date of Birth: ____ /____/_____		**SSN :** __ __ __ - __ __ - __ __ __ __		
Mailing Address:		**City**	**State**	**Zip Code**
Primary Phone: □ **Home** □ **Cell** □ **Work** ( )		**Secondary Phone:** □ **Home** □ **Cell** □ **Work** ( )		
e-mail:				
Emergency Contact Name:		**Emergency Contact Phone :** ( )		**Relationship:**
Primary Care Physician Name:		**PCP telephone :** ( ) **PCP fax :** ( )		
B. INSURANCE INFORMATION				
		DOB: ___/___/____	**ID/Policy #:**	**Group/Code:**
Subscribers name:	**Relationship:**	**Subscribers SSN:** __ __ __ - __ __ - __ __ __ __		**Effective Date:** ___/___/____
Secondary Insurance:		**DOB:** ___/___/____	**ID/Policy #:**	**Group/Code:**
Subscribers name:	**Relationship:**	**Subscribers SSN:** __ __ __ - __ __ - __ __ __ __		**Effective Date:** ___/___/____

Patient Authorization

I hereby authorize Dr. Gabriel Guerrero (Diabetes & Thyroid Care LLC) to release any information acquired in the course of my examination or treatment necessary to process insurance claims. I assign any benefits payable by my of any necessary information, including medical for any related claim to the above insurance company. I accept financial responsibility for any collection/attorney fees the physician incurs in collecting payments for which I am responsible. A copy of this agreement may be used in place of the original. This authorization may be revoked at any time in writing. I certify that all the above information stated on this form is true and accurate

_____ _____

Signature of Patient or Parent/Legal Guardian **Date**

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