91 Gregory Lane, Suite 13, Pleasant Hill, CA 94523
hello@calmedciti.com | (925)665-0008 | www.calmedciti.com

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Name: _____ Date of Birth:_____ SS#_____

Address: _____ City: _____ Zip Code: _____

Marital Status: _____ Home #:_____ Cell #: _____

Work #:_____ Email: _____

Employer: _____ Work #: _____

Referring Physician: _____ Office #: _____

Primary Care Physician: _____ Office #: _____

INSURANCE INFORMATION

Policy Holder: _____ Date of Birth:_____ SS#_____Sex: M F

Address: _____ City: _____ Zip Code: _____

Primary Insurance: _____ Phone #: _____

Address: _____ City: _____ Zip Code: _____

Group #: _____ ID #: _____ Effective Date: _____

Secondary Insurance: _____ Phone #: _____

Address: _____ City: _____ Zip Code: _____

Group #: _____ ID #: _____ Effective Date: _____

Injury is caused by: *(Please check one)* _____Workers Compensation _____Auto _____Personal Injury

Date of Injury: _____ Claim #: _____

Insurance Carrier: _____ Phone #: _____

Address: _____ City: _____ Zip Code: _____

Adjuster: _____Phone #: _____

Address: _____ City: _____ Zip Code: _____

Emergency Contact #1: _____ Relationship:_____

Cell #:_____ Email: _____

Emergency Contact #2: _____ Relationship:_____

Cell #:_____ Email: _____

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AUTHORIZATION TO RELEASE INFORMATION

I verify that all the information contained on these information sheets is true and correct, to the best of knowledge.

I hereby authorized the physician of ***Selfcare by CalMedCiti*** to release any information acquired in the course of my treatment to process insurance claims and to or from other physicians of medical facilities that may be pertinent and necessary to my care and treatment.

_____ _____

Name over Signature of Patient or Authorized Person ***Date***

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN

I hereby authorize payment of all benefits directly to the physician of ***Selfcare by CalMedCiti*** for all surgical and or medical services proceeded to me. I realize that I am responsible to forward any such monies paid to me and to pay for all co-payments, deductibles and any non-covered services. I have received and read the financial policy. I understand this policy and will adhere to the policy.

_____ _____

Name over Signature of Patient or Authorized Person ***Date***