Dr. Joseph, Brown, Lamping-Arar, Garvin & Piljan-Gentle

Patient Registration

Primary Physician:_____

Patient Name:_____ **Date of Birth:**_____ **Age:**_____

Patient Siblings:

Responsible Party Name(s):_____

Address:_____

City/ State/ Zip:_____

Primary Phone:_____ Secondary Phone:_____ Work:_____

E-Mail:_____

Mother/Parent Name:_____ DOB:_____

Mother/Parent Employer: _____ Occupation: _____

Father/Parent Name:_____ DOB:_____

Father/Parent Employer:_____Occupation:_____

Mother SS #:_____ Father SS #:_____

Custodial Party Name (If different from Responsible): _____

Address:_____

City/ State/ Zip:_____

Primary Phone:_____ Secondary Phone:_____ Work:_____

E-Mail:_____

Primary Insurance:_____

Subscriber #/ Member ID:_____ Group #:_____

Subscriber Name:_____ Birthdate:_____

Secondary Insurance:_____

Subscriber #/ Member ID:_____ Group #:_____

Subscriber Name:_____ Birthdate:_____

Preferred Pharmacy: _____ Location:_____ Phone #:_____

Emergency Contact: Name:_____ Phone #:_____

Appointment Reminder Contact: Preferred # : _____ **or** Email:_____

(Please Circle one): **Cell #** **Text** **Home #**

Preferred Language:_____

Race: (Please Circle one) AM Indian/AK Native Asian Black/African American Native HI/ Pacific IS White Prefer not to Answer

Ethnicity: (Please circle one) Hispanic Not Hispanic Prefer not to answer

I hereby authorize **Dr. Joseph, Dr. Brown, Dr. Lamping-Arar, Dr. Garvin or Dr. Piljan-Gentle** to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physicians at **3666 Paxton Avenue** and hereby direct my insurance carrier or its intermediaries to issue payment directly to **Dr. Joseph, Dr. Brown, Dr. Lamping-Arar, Dr. Garvin or Dr. Piljan-Gentle**, on behalf of such rendered services. I understand that I am financially responsible to this office for any balances not covered by my insurance carrier.

Signature:_____ **Date:**_____