PATIENT REGISTRATION

DATE_____

NAME _____ BIRTHDATE_____ AGE _____

ADDRESS _____ CITY_____ ZIP_____

HOME PHONE # _____ CELL PHONE #_____

EMAIL_____

DRIVER'S LICENSE # _____ SOCIAL SECURITY #_____

OCCUPATION _____ EMPLOYER NAME_____

BUSINESS ADDRESS _____ BUSINESS PHONE # _____

PHARMACY NAME, CITY & ZIP CODE _____

RACE: ❒ White ❒ Asian ❒ Black/African American ❒ Native Hawaiian or Other Pacific Islander
❒ American Indian-Alaskan Native ❒ Other Race

ETHNICITY: ❒ Hispanic or Latino ❒ Non-Hispanic or Latino

PREFERRED LANGUAGE: ❒ English ❒ Other _____

NAME OF SPOUSE OR PARENT (IF MINOR)_____

SPOUSE OR PARENT
EMPLOYED BY_____ OCCUPATION_____

BUSINESS ADDRESS _____ BUSINESS PHONE#_____

REFERRED BY _____ FOR_____

OTHER FAMILY MEMBERS SEEN HERE _____

NEAREST RELATIVE/FRIEND
NOT LIVING WITH PATIENT _____
NAME PHONE

INSURANCE ASSIGNMENT
AND CONSENT TO RELEASE INFORMATION

INSURANCE COMPANY_____

ADDRESS _____

ID# _____ GROUP#_____ INSURED'S DOB_____

MEDICARE #_____

FINANCIAL INFORMATION FOR MINORS
PERSON RESPONSIBLE FOR THIS ACCOUNT _____

ADDRESS _____ PHONE NO_____

I hereby authorize Elvira Klause M.D., to furnish information to the above named insurance carrier(s) concerning this condition, illness, or injury. I hereby irrevocably assign to Elvira Klause M.D., all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance and that the insurance information I have furnished is correct. I hereby authorize Elvira Klause M.D., to obtain all records/information medically necessary to treat me as a patient. A photocopy of this assignment shall be considered as valid as the original.

_____ _____
INSURED'S SIGNATURE PATIENT'S SIGNATURE