REGISTRATION FORM

PATIENT INFORMATION

o Mr. o Mrs. o Miss	Last Name	First Name	Middle	o Male o Female
Home Address (Number and Street)			Mailing Address (if different)	
City	State	Zip	City	State Zip
Primary Phone ( )	Cell Phone Ext.#( ) ( )	Date of Birth	Patient's Social Security Number -- --	
Work Phone ( )	Ext#( )	Ethnicity: Preferred Language:	Race:	
In Case of Emergency Notify	Relationship to Patient	Primary Phone Ext.# ( ) ( )	Secondary Phone Ext# ( ) ( )	
In Case of Emergency Notify	Relationship to Patient	Primary Phone Ext. #( ) ( )	Secondary Phone Ext# ( ) ( )	

GUARANTOR – PERSON RESPONSIBLE FOR PAYMENT

o Mr. o Mrs. o Miss	Last Name	First Name	Middle	Relationship to Patient Home Phone ( )
Billing Address (if different from Patient's)		City	State	Zip Code
Employed By		Ethnicity: Race: Preferred Language:	Work Phone Ext. #( ) ( )	
Employer Address (Number and Street)		Guarantor Date of Birth:		
City	State	Zip Code		

OTHER IMMEDIATE FAMILY MEMBERS SEEN AT SCP AND IN HOUSEHOLD

Spouse:	Last Name	First Name	Middle	o Male o Female	Date of Birth
Siblings:	Last Name	First Name	Middle	o Male o Female	Date of Birth
Siblings:	Last Name	First Name	Middle	o Male o Female	Date of Birth
Siblings:	Last Name	First Name	Middle	o Male o Female	Date of Birth

PRIMARY INSURANCE INFORMATION

Primary Insurance Company	Group Number	Subscriber I.D.
Subscriber's Name: Subscriber's Address:	Subscriber's Date of Birth	Relationship to Patients

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company	Group Number	Subscriber I.D.
Subscriber's Name: Subscriber's Address:	Subscriber Date of Birth	Relationship to Patients

AUTHORIZATION FOR RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to Sierra Care Physicians and I am responsible for any non-covered services, including services statutorily not covered by Medicare, Medi-Cal, or other government programs. I also authorize the release of any information required for the processing of claims.

I certify that, to the best of my knowledge, the patient registration information is current.

I authorize the creditor or his agent to make a credit investigation, including employment verification.

SIGNATURE and Print Name Account Guarantor/Responsible Party

Today's Date

SIERRA CARE PHYSICIANS
140 Litton Dr., Suite 100, Pediatrics, Grass Valley, CA 95945
140 Litton Dr., Suite 100, Family Practice, Grass Valley, CA 95945
11400 Pleasant Valley Road, Family Practice, Grass Valley, CA 95946

Patient Name: _____ DOB: _____

Name of Pharmacy: _____

I acknowledge that I have received a copy of the HIPAA Notice of Privacy.

Are you known as any other name? If yes, please print name: _____

Please name all person(s) we can contact and /or discuss your medical and financial information with:

_____	_____	_(_)_____/_____
Name	Relationship	Phone No. Cell
_____	_____	_(_)_____/_____
Name	Relationship	Phone No. Cell
_____	_____	_(_)_____/_____
Name	Relationship	Phone No. Cell

May we leave messages on your home and cell phone numbers? YES___ NO ___

May we leave an ___ Extended or ___ Brief Message?

Email: _____

_____ _____
Print Name: Patient/Parent/Guardian (circle one) Date

_____ _____
Signature of: Patient/Parent/Guardian (circle one) Date