



Pacific Breast Care Patient Registration Form

PATIENT INFORMATION

Referring Doctor: _____

Name: _____

Street: _____

City, State, Zip: _____

Home/Mobile Phone: _____

Email: _____

Work Phone: _____

Primary Care Doctor: _____

Gender: Female Male

Date of Birth: _____ Age: _____

Social Security #: _____ — _____ — _____

Marital Status: Married Single

Divorced Widowed Domestic Partner

Employer: _____

PRIMARY INSURANCE

Insured Party: _____

Insurance Carrier: _____

Claims Address: _____

Claims Phone: _____

Relationship to Patient: _____

Insured Date of Birth: _____

Insured ID / Cert. #: _____

Policy Group #: _____

Insured Social Security #: _____ — _____ — _____

SECONDARY INSURANCE

Insured Party: _____

Insurance Carrier: _____

Claims Address: _____

Claims Phone: _____

Relationship to Patient: _____

Insured Date of Birth: _____

Insured ID / Cert. #: _____

Policy Group #: _____

Insured Social Security #: _____ — _____ — _____

EMERGENCY CONTACTS

Name: _____

Mobile Phone: _____

Relationship: _____

Work phone: _____

Assignment of Benefits and Signature on File

I authorize direct payment to the above-named provider. I authorize the use of this form for all insurance submissions, and permit a copy of this to be used in place of the original. I authorize this provider to act as my agent in helping me obtain payment from my insurance company. I expressly revoke all prior revocations of any assignment of benefits. In the event that my current policy prohibits direct payment to the provider, then I hereby instruct and direct you to make out the check to me and mail it in care of the above-named provider.

I certify that all of the information is true and correct to the best of my knowledge. I will notify you of any changes in my health, the above information, or any pertinent information.

I understand that I am responsible for any fees of any services rendered to me, regardless of any insurance or financial status.

Signature: _____

Date: _____

Parent/Guardian of Minor: _____

Date: _____

STAFF ONLY	PATIENT ID:
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