

# Pleasant Hill Wellness Center

A Medical Corporation

## Patient Registration Form

### Patient Information:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

First

Middle Initial

Last

Address: \_\_\_\_\_

Street

Apt. #

City/State

Zip

Birthdate: \_\_\_\_\_ Sex: \_\_\_ (F) \_\_\_ (M) Marital Status: \_\_\_ (S) \_\_\_ (M) \_\_\_ (D) \_\_\_ (W)

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ SS#: \_\_\_\_\_

Mobile Phone (\_\_\_\_) \_\_\_\_\_ E-mail Address \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer (Pt. or Resp. Party): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Is this a work related injury?: \_\_\_ (Y) \_\_\_ (N) Is this an auto accident related injury?: \_\_\_ (Y) \_\_\_ (N)

### Insurance Information

Primary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Company

Address: \_\_\_\_\_

Group #: \_\_\_\_\_ ID #: \_\_\_\_\_ Plan #: \_\_\_\_\_ Eff. Date: \_\_\_\_\_

Card Holder Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Card Holder Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Company

Address: \_\_\_\_\_

Group #: \_\_\_\_\_ ID #: \_\_\_\_\_ Plan #: \_\_\_\_\_ Eff. Date: \_\_\_\_\_

### Emergency Contacts:

1. Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Address: \_\_\_\_\_ Employer: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Address: \_\_\_\_\_ Employer: \_\_\_\_\_

How did you hear about the Pleasant Hill Wellness Center?

\_\_\_ Friend/Relative \_\_\_ Advertisement \_\_\_ Insurance \_\_\_ Chamber of Commerce \_\_\_ Other \_\_\_\_\_

Please List

### Assignment of Benefits

*I hereby assign medical and/or surgical payments to include major medical benefits to which I am entitled, private insurance and other health plans to the Pleasant Hill Wellness Center - A Medical Corporation. This Assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure the payment.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_