

## WELCOME TO MY OFFICE

### Patient Registration

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ S.S. Number: \_\_\_\_\_ Marital Status:  Single  Married  Separated  Divorced

Occupation: \_\_\_\_\_ Employed By: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Spouse's Name (or parent if patient is under 18): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ S.S. Number: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employed By: \_\_\_\_\_ Business Phone \_\_\_\_\_

Employer's Address: \_\_\_\_\_

### IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

### Beneficiary Statement

I, the undersigned, certify that I, or my dependent, have insurance coverage with the company listed above. I understand that I am financially responsible for co-payments, deductibles of any balance after insurance, as outlined in the explanation benefits. I request that payment of authorized benefit and all third-party insurance carriers, be made either to me or on my behalf to Dr. Riachi's office for services furnished to me in this facility. I authorize any holder if medical information needed to determine these benefits payable for the related services rendered. Comprehensive Reports, Forms, Copies of records are payable in advance.

Authorized Signature: \_\_\_\_\_