MT. DIABLO INTEGRATED WELLNESS CENTER

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NEW PATIENT REGISTRATION FORM

Patient Name: _____
Address: _____
_____
Email: _____

Sex: ___Male ___Female Birth Date: _____ Age: ___ Social Sec #: _____

Marital Status: __Single __Married __Divorced __Widowed
How did you learn about us: __Friend __Relative __Internet
Physician: _____

Home Phone: _____ Work Phone: _____ Email: _____
Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____
Home Phone: (_____) _____ Work Phone: (_____) _____

Who is financially responsible for payment for these services?
__Self __Spouse __Parent/Guardian __Workers Comp Other: _____

Responsible Party or Bill to Information:
Full Name: _____ Relationship: _____ _
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ Work Phone: (_____) _____
Birth Date: _____ Age: _____ Social Sec. #: _____
Employer: _____

Insurance Information:
Insurance company name: _____ Plan Name: _____
Type of plan: ___PPO ___POS ___HMO ___ Medicaid ___ Medicare ___ Tricare ___ Medicare HMO ___ WC ___ Lien
Policy #: _____ Group #: _____
Copay: _____ Is plan through employer? ___ Yes ___ No
Employer Address: _____ Occupation: _____

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in this clinic's Notice of Privacy Practices. I authorize my insurance benefits be paid directly to MDI Wellness as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage.

Signature: _____ Date: _____