

MT. DIABLO INTEGRATED WELLNESS CENTER

Suprabha Jain, MD

2810 LONE TREE WAY UNIT 6

ANTIOCH, CA 94509

Phone: (925) 935-5425, Fax: (925) 947-2671

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: _____