MT. DIABLO INTEGRATED WELLNESS CENTER

6200 Stoneridge Mall Rd Suite 300
Pleasanton CA 94588
Phone: (925) 935-5425, Fax: (925) 947-2671

NEW PATIENT REGISTRATION FORM

Patient Name: _____
Address: _____
_____
_____

Social Sec #: _____
Sex: ___Male ___Female Birth Date: _____ Age: _____
Marital Status: __Single __Married __Divorced __Widowed
How did you learn about us: __Friend __Relative __Yellow Pages
Physician: _____

Home Phone: _____Work Phone: _____
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: _____