PATIENT REGISTRATION

Patient's Name ______________________________ Date of Birth __________ Age ______
Last First MI
Address ____
Street City State Zip
Home #__________ Cell # __________ Work # __________ E-Mail ______________
Preferred Method of Contact: ☐ Home # ☐ Cell # ☐ E-Mail
Social Security # __________ Marital Status ______ Employer __________ Occupation __________
Address ____
Street City State Zip
REFERRED BY____

Name of Spouse or Responsible Party ______________ Relationship ______ Age___ Date of Birth ______
Address ____
Street City State Zip
Home # ______________ Cell # ______________ Work # ______________
Social Security # ______________ Employer ______________ Occupation ______________
Address ____
Street City State Zip

Name of relative NOT living with you ______________
Relationship________ Phone Number__________
Address ______________________________
Street City State Zip

Name of friend NOT living with you______________
Relationship________ Phone Number__________
Address ______________________________
Street City State Zip

INSURANCE INFORMATION
We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.
Name of Primary Insurance Carrier ______________________ Policy Effective Date__________
Address ____
Street City State Zip
Phone __________ Insured's Name______________ Policy # ________ Group # ________
Secondary Insurance Carrier ______________________ Policy Effective Date__________
Address ____
Street City State Zip
Phone __________ Insured's Name______________ Policy # ________ Group # ________

INSURANCE AUTHORIZATION AND ASSIGNMENT

I Hereby authorize release of any medical information necessary to process any insurance claims with my insurance company and assign benefits otherwise payable to me to the physician or group indicated on the claim. I understand that I am responsible for any deductibles, co-insurance/or amounts for services not covered by the insurance carrier. All professional services rendered are charged to the patient. I further authorize release of all pertinent medical records to my physician at Desert Perinatal Associates for continuing medical treatment.

The patient is responsible for all fees regardless of insurance coverage. In the event of collection proceeding due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to the physician. A copy of signature is as valid as the original.

____
Signature of Patient or Responsible Party (if minor)

____
Print Patient Name Date

Southwest Location: 5761 S. Ft. Apache • Las Vegas, Nevada 89148
Summerlin Location: 10105 Banburry Cross, #430 • Las Vegas, Nevada 89144
Green Valley Location: 3001 Horizon Ridge Parkway • Henderson, Nevada 89052
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