Kat Motlagh's Health Clinics

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's Last Name	First Name	MI		Marital Status
			☐Mr. ☐ Miss ☐Mrs. ☐ Ms.	☐ Single ☐ Marr ☐ Div ☐ Sep ☐ Wid

Home Address	PO / Apt #	City	State	Zip Code

Social Security Number	Drivers License	Birth Date / /	Age	Sex
				☐ Male ☐ Female

Email Address	Phone Number	Cell Phone
	( )	( )

Ethnicity	Race	Spoken Language

Employer	Employer Address	Employer Phone
		( )

INSURANCE INFORMATION

PLEASE GIVE YOUR INSURANCE CARD / ID CARD TO THE RECEPTIONIST

Primary Insurance Name	Type of Insurance
	☐ PPO ☐ PPS ☐ Medicare ☐ Manage Care / HMO ☐ Other

Address (if different)	Home Phone (if different)
	( )

Subscriber's Name	Social Security Number	Birth Date
		/ /

Relationship to Subscriber	Co-Pay Amount	Group #	Policy #
☐ Self ☐ Spouse ☐ Child ☐ Other	$		

Secondary Insurance Name	Type of Insurance
	☐ PPO ☐ PPS ☐ Medicare ☐ Manage Care / HMO ☐ Other

Subscriber's Name	Social Security Number	Birth Date
		/ /

Relationship to Subscriber	Co-Pay Amount	Group #	Policy #
☐ Self ☐ Spouse ☐ Child ☐ Other	$		

EMERGENCY CONTACT

Name of Local Individual (Not Living at the same address)	Relationship	Home Phone	Work Phone
		( )	( )

The above information is true to the best of my knowledge. I authorized my insurance benefits be paid directly to the physician. _____ Please initial. I understand that I am financially responsible for any balance. I understand any Laboratory charges are separate and I will b billed by an outside lab. _____ Please initial. I also authorize Kat Motlagh's Health Clinic or insurance company to release any information required to process my claims. _____ Please initial

Patient / Guardian Signature: _____ **Date:** _____