### Allen Kamrava, M.D. M.B.A., Inc.

# REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PCP: | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | | | | | | | | | | | | First: | | | | | | | | | | | | Middle: | | | | | ❑ Mr.  ❑ Mrs. | | | | ❑ Miss  ❑ Ms. | | | | | | | | Marital status (circle one) | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Single / Mar / Div / Sep / Wid | | | | | | | | | | | |
| Is this your legal name? | | | | | | If not, what is your legal name? | | | | | | | | | | | | | | | | | | | | | (Former name): | | | | | | | | | | | | | | | | Birth date: | | | | | | | | Age: | | | Sex: | | | | |
| ❑ Yes | | ❑ No | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | / / | | | | | | | |  | | | ❑ M | | | ❑ F | |
| Street address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Social Security no.: | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | | |
| P.O. box: | | | | | | | | | | City: | | | | | | | | | | | | | | | | | | | | | | | | | | | State: | | | | | | | | | | | | ZIP Code: | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | |
| Occupation: | | | | | | | | | | Employer: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | | | |
| Chose clinic because/Referred to clinic by (please check one box): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ❑ Dr. | | |  | | | | | | | | | | | | | | | | ❑ Insurance Plan | | | | | | | | ❑ Hospital | | |
| ❑ Family | | | ❑ Friend | | | | ❑ Close to home/work | | | | | | | | | | | | | | | | | ❑ Yellow Pages | | | | | | | | | | | | | ❑ Other | | | | | | |  | | | | | | | | | | | | | | |
| Other family members seen here: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Please give your insurance card to the receptionist.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Person responsible for bill: | | | | | | | | Birth date: | | | | | | | | | | | | | Address (if different): | | | | | | | | | | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | | | | | |
|  | | | | | | | | / / | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | | | |
| Is this person a patient here? | | | | | | | | ❑ Yes | | | | | | | | ❑ No | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Occupation: | | | | Employer: | | | | | | | | | | | Employer address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | | | |
| Is this patient covered by insurance? | | | | | | | | | | | | ❑ Yes | | | | | | | | ❑ No | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please indicate primary insurance | | | | | | | | | ❑ | | | | | | | | | | | | | | ❑ | | | | | | | | | | ❑ | | | | | | | | | | | | ❑ | | | | | | | | ❑ | | | | | |
| ❑ | | | | | ❑ | | | | | | | | | | | | ❑ | | | | | | | | | ❑ Welfare (Please provide coupon) | | | | | | | | | | | | | | | | | | | ❑ Other | | | | |  | | | | | | | | |
| Subscriber’s name: | | | | | | | | | Subscriber’s S.S. no.: | | | | | | | | | | | | | | | | Birth date: | | | | | | | | | Group no.: | | | | | | | | | | | | Policy no.: | | | | | | | | | Co-payment: | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | | | | / / | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | $ | | | |
| Patient’s relationship to subscriber: | | | | | | | | | | | | | ❑ Self | | | | | | | | | ❑ Spouse | | | | | | | ❑ Child | | | | | ❑ Other | | | | | | |  | | | | | | | | | | | | | | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | | | | | | | | | | | | Subscriber’s name: | | | | | | | | | | | | | | | | | | | | | | Group no.: | | | | | | | | | | | Policy no.: | | | | | | |
|  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | |
| Patient’s relationship to subscriber: | | | | | | | | | | | | | | ❑ Self | | | | | | | | ❑ Spouse | | | | | | | ❑ Child | | | | | ❑ Other | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of local friend or relative (not living at same address): | | | | | | | | | | | | | | | | | | | | | | | | | | | | Relationship to patient: | | | | | | | | | | | | Home phone no.: | | | | | | | | | | | Work phone no.: | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | ( ) | | | | | | | | | | | ( ) | | | | | | | |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | | |  |
|  | Patient/Guardian signature | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Date | | | | | | | | | | | | | | | |  |