### 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 |  |