SIERRA MADRE COMMUNITY MEDICAL GROUP

147 W. Sierra Madre Boulevard, Sierra Madre, CA 91024

PATIENT REGISTRATION

Welcome to Sierra Madre Community Medical Group

Full Name (Last, First, Middle): _____

Title (circle one): Mr. Mrs. Miss Dr.

Marital Status (circle one): Single Married Divorced Separated Widowed

Address: _____ Apt #: _____

City/State/Zip: _____

Email Address: _____ Occupation: _____

Home Telephone: _____ Employer: _____

Cellular Phone: _____

Emergency Contacts

Name: _____ Relationship to Patient: _____ Tel: (____)_____

Name: _____ Relationship to Patient: _____ Tel: (____)_____

Driver License #: _____

How Were You Referred to Sierra Madre Community Medical Group?

_____

- If you would like to give authorization to share your protected health information or allow somebody to pick up your prescriptions or laboratory slips, please ask the receptionist for the form titled "AUTHORIZATION OF RELEASE OF MEDICAL RECORD."

- If the patient is a minor, ask the receptionist for "AUTHORIZATION FOR SERVICES RENDERED TO A MINOR."

- The physicians of Sierra Madre Community Medical Group might order some laboratory tests that need to be performed for diagnostic and screening purposes. We are going to direct you to a laboratory contracted with your insurance. You are responsible to check if the tests ordered on the laboratory slip are covered by your insurance and if they apply toward your deductible.

- I hereby authorize the office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges regardless of insurance coverage.

_____ _____

Signature of Patient or Representative Date