Diabetes Care Center
A Medical Corporation
1260 SOUTH MAIN ST., STE 201 * SALINAS, CA 93901
(831) 769-9355 * FAX (831) 754-4955

PATIENT REGISTRATION FORM

RECEPTION INIT.

PATIENT'S ACCOUNT #	RESPONSIBLE PARTY	CHART NUMBER	CATEGORY

NAME (LAST, FIRST, MIDDLE, INT.)	HOME PHONE NO.	DOB	DRIVERS LICENSE

ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY NO.	SEX (M/F)	MARITAL STATUS	LAST TETANUS

OCCUPATION	EMPLOYER	EMPLOYER PHONE #

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

PRIMARY CARE DOCTOR:	REFERRED BY:	IN CASE OF EMERGENCY CONTACT PERSON AND PHONE NO.	(RELATIONSHIP)

PRIMARY INSURANCE INFO.
PLEASE PROVIDE COPY OF INSURANCE CARD

INSURANCE NAME	
INSURANCE ADDRESS	PHONE #

SUBSCRIBER ID#	GROUP #	PLAN #	COVERAGE BEGIN DATE:

ANNUAL DEDUCTIBLE	CO-PAYMENT	INSUREDS NAME	INSUREDS DATE OF BIRTH

INSUREDS SEX (M/F)	INSUREDS PHONE NO.	INSUREDS SOCIAL SECURITY NO.

INSUREDS ADDRESS	CITY	STATE	ZIP CODE

INSUREDS EMPLOYER	EMPLOYER'S PHONE NO.

EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

SECONDARY INSURANCE INFO.
PLEASE PROVIDE COPY OF INSURANCE CARD

INSURANCE NAME	
INSURANCE ADDRESS	PHONE #

SUBSCRIBER ID#	GROUP #	PLAN #	COVERAGE BEGIN DATE:

ANNUAL DEDUCTIBLE	CO-PAYMENT	INSUREDS NAME	INSUREDS DATE OF BIRTH

INSUREDS SEX (M/F)	INSUREDS PHONE NO.	INSUREDS SOCIAL SECURITY NO.

INSUREDS ADDRESS	CITY	STATE	ZIP CODE

INSUREDS EMPLOYER	EMPLOYER'S PHONE NO.

EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

I authorize payment of medical benefits be made directly to the physician provider for services rendered. I am financially responsible for all CO-payments and non-covered services.

I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information to this claim and the expenses reported, either by mail or fax.

DATE

SIGNED (Insured or Authorized)