--PATIENT REGISTRATION--

WELCOME! Please complete this form in full, leaving no blanks. If anything does not apply, please indicate so. Then read and sign the last portion.

Please Print Clearly

Name_____ _____Birth-date_____Age_____
Last First M.I.

Address_____City_____State_____ Zip_____

Home Phone( )_____Work( )_____Cell( )_____

Sex ☐ M ☐ F Soc. Sec #_____ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

If Patient is a minor, please indicate Parent Information

Your Employer_____Occupation_____

Spouse/Partner Name_____

Spouse/Partner Employer_____Spouse/Partner Work Phone_____

***Name of Primary Care Physician_____ ***Name of Referring Physician_____

Name & Phone Number of Friend/Relative not living with you, we may contact in a case of an emergency:

_____
Name Relation Phone

Primary Insurance Company_____Subscriber (circle) Self Spouse/Partner Parent

Subscriber other than Self: Name_____Birth-date_____

Soc. Sec #_____I.D. Number_____Group #_____

Secondary Insurance Company_____Subscriber (circle) Self Spouse/Partner Parent

Subscriber other than Self: Name_____Birth-date_____

Soc. Sec #_____I.D. Number_____Group #_____

I, the undersigned certify that I (or my dependent) have insurance coverage with the above mentioned insurance company and assign directly to Dr. Norris all insurance benefits, if any otherwise payable to me for services rendered. I hereby authorize the Doctor to release all information necessary to secure the payment of my benefits. I authorize the use of this signature on all insurance submissions. I understand that even though Dr. Norris may obtain pre authorization for a service, procedure or surgery from my insurance company they will not guarantee payment for medical necessity until they have done a post procedure review. I understand that I am financially responsible for all charges whether or not paid by insurance. Your physician Dr. Michael Norris may have ownership interest in the San Mateo Surgery Center to which Dr. Michael Norris may refer you to for a surgical procedure. Your choosing another facility will not adversely impact your treatment.

_____ _____ _____
Responsible Party Signature Relationship Date