Sutter Pacific Medical Foundation
A Sutter Health Affiliate
With You. For Life.

SUTTER PACIFIC MEDICAL FOUNDATION
NEW PATIENT REGISTRATION FORM
(PLEASE PRINT)

PEDIATRIC

Today's Date:			PCP:	
PATIENT INFORMATION				
Patient's last name:	First	Middle		Patient DOB:
Street address:			Home phone no:	( )
City:	State:	ZIP Code:	Work phone no:	( )
E-mail:			Cell phone no:	( )
Pharmacy Name & Address:			OK to leave message?	❒ Yes ❒ No
Occupation:	Employer:		Employer phone no:	( )
Street address:	City:	State:		ZIP Code:
Parent /Guardian Name(s):				
Guarantor Birth date: Age:	Sex: ❒ M ❒ F	Guarantor Social Security No.:		
Who referred you to this office?				

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):			Home phone no: ( )
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❒ Parent ❒ Relative ❒ Friend ❒ Other				
Primary Insurance Carrier:	Claim #:	Person authorizing treatment:			Phone no: ( )
Street address:	City:	State:			ZIP Code:
Secondary Insurance Carrier (if applicable):	Subscriber's name:	Group no.:			Policy no.:
Patient's relationship to subscriber:	❒ Parent ❒ Relative ❒ Friend ❒ Other				

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Daytime phone no: ( )	Evening phone no: ( )

I hereby authorize and request my insurance company to pay directly to the provider, the amount(s) due on a claim for services rendered to me or my dependents. I further agree should the amount be insufficient to cover the medical and/or surgical expenses, I will be responsible for payment of the difference(s), according to the explanation of benefits. If the nature of the office visit is not covered by the policy, I will be financially responsible to pay the provider the amount of the entire bill.

I hereby authorize treatment of the patient named above and agree to pay all charges at the time services are rendered, unless other arrangements are agreed upon in advance. If payment of my account is over 60 days late, or it goes to collection, all fees including collection, attorney fees and applicable finance charges will be my responsibility. I hereby authorize the release of any information necessary for payment of charges incurred.

Patient/Guardian Signature:	***Date:***