RACQUEL S. QUEMA, M.D., INC.

REGISTRATION FORM

(Please Print)

Today's date:	Attending Physician: Racquel Quema, M.D.

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? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street Address:	Apt No. / P.O. box:

City:	State:	ZIP Code:

Home phone: ( )	Mobile phone: ( )	Email:	Preferred communication: ( ) Phone ( ) Email ( ) Text

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Internet	❑ Other

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

Name of primary insurance	

Subscriber's name if different from Patient:	Birth date: / /	Group no:	Policy no:

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 : ( )	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 Dr. Racquel Quema or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

GENERAL CONSENT TO TREAT AND HIPAA NOTICE

I consent to medical care of a routine/emergency nature from the authorized professional staff of *Racquel S. Quema, M.D., Inc.* for myself or the above-mentioned minor for whom I am the parent/guardian.

I authorize my insurance benefits, if any to be paid directly to *Racquel S. Quema, M.D., Inc.* I understand that I am financially responsible for any balance (for example, co-pays, co-shares, deductibles, etc).

I also authorize *Racquel S. Quema, M.D., Inc.* or insurance company to release any information required to process my claims.

I acknowledge that I received Notice of Privacy Practices for *Racquel S. Quema, M.D., Inc.* and that I may obtain a paper copy of this Notice of Privacy Practices.

Patient or Guarantor Signature: _____ Date: _____

Printed Name: _____

CONSENTIMIENTO GENERAL PARA TRATAR Y DECLARACION HIPAA

Autorizo a la atencion medica de caracter rutinario / de emergencia del personal profesional autorizado de *Racquel S. Quema, M.D., Inc.* por mi mismo o por el menor mencionado anteriormente por quien soy el padre / tutor.

Yo autorizo mis beneficios de seguro, si los hubiera, a ser pagados directamente a *Racquel S. Quema, M.D., Inc.* Entiendo que soy financieramente responsible de cualquier saldo (por ehemplo, copagos, deducibles, etc).

Tambien autorizo a *Racquel S. Quema, M.D., Inc.* o compania de seguros a divulgar cualquier informacion requerida para procesar mis reclamaciones.

Acuso recibo del Aviso de Practicas de Privacidad de *Racquel S. Quema, M.D., Inc.* y que puedo obtener una copia en papel de esta Aviso de Practicas de Privacidad.

Ferma del Paciente o Garante: _____ Fecha: _____

Imprimir Nombre: _____

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