Patient Registration

Last Name: First:

Address: City: State: Zip:

Birth Date: Sex: Male[] Female[] Email:

Marital Status: Soc. Security#:

Employer: Occupation:

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Referring Physician First and Last Name:
Phone:

Work Related Injury: Yes[] No []
Workers' Compensation carrier name:

Address City: State: Zip:

Adjuster's Name: Phone:

Date of Injury: Claim No#

Primary Health Insurance Name: HMO [] authorization req. PPO[] Indemnity[]

I.D.#: Group No# Effective:

Subscriber Name:

Address: City: State: Zip:

Second Insurance Name: HMO[]authorization req. PPO[] Indemnity[]

Address: City: State: Zip:

I.D.#: Group No#: Effective:

Please see attached HIPAA Privacy Practices Notice.
I have read and signed the HIPAA Privacy Practices Notice: Yes[] No []

Office Policy: Please be aware David G. Mohler, M.D. is not participating with any insurance carriers. We ask for payment at the time of service, you will be given a statement at the end of your office visit to bill your health insurance. We will bill Medicare and your secondary insurance carrier as required by law. We do not participate with Medi-Cal. I hereby authorize David G. Mohler, M.D. to use signature(s) below as authorized to release medical or other information as necessary.

Signed Date