Aguilar Family Health Care
Nick S. Aguilar M.D.
PATIENT REGISTRATION FORM

Patient Name: ____ **Sex:** Male: ___ Female : ___ **Age:**_________
Last Name First Name Middle Initial

Social Security: ________________ **DOB :** __________ **Marital Status:** Married: ____ Single:____Divorced ___ Widowed: ____

Address:_______________________________ **City:**____________________ **State:**______________ **Zip**____________

Phone #:___________________________ **Email:**____

Race: Asian: _____ White: _____ Black or African American: _____ American Indian or Alaska Native: _____

Native Hawaiian or other Pacific Islander: _____ Patient Declined: _____

You May Select Two Race Selections

Preferred Language: English: _____ Spanish: _____ Patient Declined :_____

Ethnicity: Hispanic or Latino: _____ Non Hispanic or Latino: _____ Patient Declined: _____

Employer:____ **Occupation:**___________________________

Employer Address: ____ **Business Phone:**______________________

PERSON RESPONSIBLE FOR ACCOUNT SAME AS ABOVE: YES:_____ NO:_____ ***IF NO PLEASE FILL OUT BELOW***

Name of Responsible Party: ____
Last Name First Name Middle Initial

Address (If Different from Patient):______________________________________ **City:**___________________________

State:______________ **Zip:**_____________

Employer:____ **Occupation:**_________________________________

Employer Address: ____ **Business Phone:**______________________

Social Security: ___________________ **DOB :** _______________

PLEASE GIVE EMERGENCY INFORMATION FOR A PERSON WHO DOES NOT LIVE WITH YOU

Name: __________________________________ **Relationship:**________________ **Phone Number:**_______________

PERSON RESPONSIBLE FOR ACCOUNT (IF PATIENT IS A MINOR)

Name of Responsible Party: ____
Last Name First Name Middle Initial

Are you the Legal Guardian? Yes: _____ No: _____ **Social Security:** __________________________

Address (If Different from Patient):______________________________________ **City:**___________________________

State:______________ **Zip:**_____________

Employer:____ **Occupation:**_________________________________

Employer Address: ____ **Business Phone:**________________________

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Nick S. Aguilar M.D.
PRIMARY INSURANCE INFORMATION

Name of Insurance Company:____

Mailing address for claims:__________________________ **City:**__________________ **State**___________ **Zip**_________

Phone number:___________________________________ **Policy holder:**____

Id#____________________________________ **Group #**_______________________ **Member #**______________________

SECONDARY INSURANCE INFORMATION

Name of Insurance Company:____

Mailing Address for Claims:__________________________ **City:**_________________ **State:**__________**Zip:**_________

Phone number:___________________________________ **Policy holder:**____

Id#____________________________________ **Group #**_______________________ **Member #**______________________

PERMISSION TO TREAT PATIENT

I hereby authorize medical care by **Nick S. Aguilar MD, PA** for the person named above as "patient" on this document. I also give **Aguilar Family Health Care** permission to file on my insurance payment for my medical care and/or procedures. I also understand that I am financially responsible for all charges not covered by my insurance for services rendered on my behalf or my dependents.

PATIENT SIGNATURE:____________________________________**WITNESS:**_____________________________________

GUARDIAN SIGNATURE:__________________________________**WITNESS:**_____________________________________

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to **Aguilar Family Health Care** of all insurance benefits related to my care. I authorize **Aguilar Family Health Care** to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I also understand that i may be responsible for any co-payment due at time of any and all office visit(s).

PATIENT SIGNATURE:____________________________________ **WITNESS:**_____________________________________

GUARDIAN SIGNATURE:__________________________________**WITNESS:**_____________________________________

MEDICARE AUTHORIZATION

I request that payment of my Medicare benefits be made to Nick S. Aguilar MD, PA on my behalf for any services furnished by **Aguilar Family Health Care** or under their direction. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ I ACKNOWLEDGE IF I WANT A VISIT SUMMARY IT WILL BE PROVIDED FOR PICK UP AT THE OFFICE WITHIN THREE BUSINESS DAYS OF MY VISIT