REGISTRATION FORM

(Please Complete All Sections) Today's Date ____/_____/_____

PATIENT INFORMATION

Patient's Last Name First Middle	Marital Status
Street Address City State ZIP Code	DOB: Social Security
Email:	Preferred Phone No

May we contact you via email and set up Patient Portal? ☐ Yes ☐ No

Receive Text Reminder & Patients statements? ☐ Yes ☐ No

Preferred Pharmacy: _____

Preferred Lab: _____Preferred Diag. Center: _____

INSURANCE INFORMATION

Name of Primary Insurance	Subscriber's Name
Subscriber's DOB:	Policy #: Group #

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of Secondary Insurance (If applicable)	Subscriber's Name
Subscriber's DOB:	Policy #: Group #

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative Relationship to Patient Home Phone #: Cell Phone #

The above information is true to the best of my knowledge. I authorize my insurance benefits to pay directly to Rois Ojeda Medical Services, LLC. I understand that I am financially responsible for any balances. I also authorize Rois Ojeda Medical Services, LLC or insurance company to release any information required to process my claims.

Patient/Guardian Signature_____ Date _____