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

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


**ADULT**

| | | | | | |
|---|---|---|---|---|---|
| Today's Date: | | | PCP: | | |
| **PATIENT INFORMATION** | | | | | |
| Patient's last name: | First | Middle | ❒ Mr. ❒ Miss ❒ Mrs. ❒ Ms. | | |
| **MARITAL STATUS:** ❒ Single ❒ Partnered ❒ Married ❒ Separated ❒ Divorced ❒ Widowed | | | | | |
| Birth date: Age: | Sex: ❒ M ❒ F | Social Security No.: | | | |
| 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: | | |
| **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: | ❒ Self ❒ Spouse ❒ Child ❒ 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: | ❒ Self ❒ Spouse ❒ Child ❒ 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:*** |