Glenna R Andersen, M.D. & Darya B.Maanavi, M.D., Ltd.

Patient Registration Form

Date:

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Date of Birth:
Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact for reminder calls and other electronically generated messages: (Please Circle All) Voice Email Home		Email Address	
Emergency Contact Name, Relationship and Contact Phone Number:		Primary Care Physician:	
Marital Status: (circle) S M P D W	Social Security #:		
Employer Name:	Occupation		

Additional Information and Responsible Party

Responsible Party (If patient is under 18, parent or legal guardian information

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Spouse/Partner/Father of Baby Name (Circle One) **Occupation:**	☐
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Sign Language ☐ Spanish ☐ ☐ ☐ ☐	
Preferred Pharmacy Name, address and phone number:	

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I understand that payment to Glenna R. Andersen & Darya B. Maanavi, Ltd. and their providers is my responsibility regardless of insurance coverage. I hereby assign to Drs. Andersen & Maanavi and their providers all reimbursable benefits paid by my insurance carrer to which I am entitled for medical expenses related to the services performed. I authorize that any medical information may be released to my insurance carrier or third party payer to facilitate processing my insurance claims. I agree to pay for any outstanding balance owed within thirty (30) days of receiving notification of payment from my insurance carrier and/or the office of Glenna R. Andersen, M.D. & Darya B. Maanavi, Ltd. I understand that failure to pay outstanding balances within sixty (60) days of notification of the amount due will result in submission to an outside collection agency. In this event a 33 and 1/2 collection fee will be incurred that I will be responsible for. A $30.00 returned check fee will be charged for checks returned due to insufficient funds.

MEDICARE BENEFICIARIES INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized Medicare (Including Medicare/Medigap) benefits paid on my behalf be made to Glenna R. Andersen, M.D. & Darya B. Maanavi, M.D., Ltd. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I understasnd I am responsible for any amount not covered by insurance.

I have been given and reviewed a copy of Glenna R. Andersen, M.D. & Darya B. Maanavi M.D, Ltd. Privacy Practice Notice.

Signature of Responsible Party: **X** _____ **Date:**

Printed Name of Responsible Party: **X** _____ **Date:**

Rev. 3.2016